PERMISSION TO DISCLOSE PROTECTED HEALTH INFORMATION
CONSENT AND ACKNOWLEDGEMENT FOR
ETOWAH GASTROENTEROLOGY ASSOCIATES, P.C.
(PLEASE PRINT)

Patient Name: _____ Date of Birth: _____
Patient Address: _____ SSN: _____
_____

I give Etowah Gastroenterology Associates, P.C. permission to release medical information to the follow persons:

☐ None-Patient Only ☐ Children_____
☐ Parents _____ ☐ Spouse _____
☐ Father (only) _____ ☐ Mother (only) _____
☐ Other _____ ☐ Guardian _____
☐ Physicians _____ Fax # _____ Phone # _____

I wish to be contacted in the following manner by Etowah Gastroenterology Associates, P.C. (check all that apply):

☐ **Home Telephone** _____
- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call back number only

☐ **Cell Phone** _____
- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call back number only

☐ **Work Telephone** _____
- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call back number only

☐ **Written Communication**
- ☐ O.K. to mail or Email to my home address
- ☐ O.K. to mail or Email to my work/office
- ☐ O.K. to fax to this number

☐ **Other (Email Address)** _____
_____
_____
_____
_____

The Privacy Act generally requires healthcare providers to take responsible steps to limit the use of disclosure of and requests for protected health information to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of protected health information disclosures. Information provided below, if completed properly, will constitute an adequate record.

Consent:
I consent to the use and disclosure of protected health information about me by my physician and my physician's practice for purposes of treatment, payment, health care operations, protection of others and disclosures required by law, including information about notifiable diseases, sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS) and human immunodeficiency virus (HIV).

NOTE: Uses and disclosures for protected health information may be permitted without prior consent in an emergency.

ACKNOWLEDGMENTS:
I acknowledge that I have received Etowah Gastroenterology Associates, P.C. Notice of Privacy Practices.

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Relationship of Personal Representative to the Patient Signature of Witness

_____
Print Personal Representative's Name