ADVANCED DIGESTIVE CARE
ASSOCIATES IN GASTROENTEROLOGY

COMMUNICATION AUTHORIZATION

In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Associates in Gastroenterology, P.C. will not release confidential health information, either in person or by telephone, email, or fax to any unauthorized people. When returning telephone calls, we will not leave a message on an answering machine or voicemail unless we are authorized in writing to do so. Also, information will not be given to an unauthorized person who may answer your telephone (either at home or at work).

If you would like to authorize us to release medical information to someone other than yourself or to leave information on a recording device, please complete the following:

I authorize the physicians and staff of Associates in Gastroenterology, P.C. to release confidential medical information pertaining to my care by the following methods and to the following people. I understand that it is my responsibility to notify Associates in Gastroenterology, P.C. if this authorization information changes.

It is okay to leave confidential medical information for me on my: (list numbers)

□ Home telephone/answering machine _____
□ Work telephone _____
□ Mobile telephone _____

It is okay to give confidential medical information to my: (list names)

□ Spouse: _____
□ Parent(s): _____
□ Son/Daughter: _____
□ Brother/Sister: _____
□ Other: _____

I acknowledge that this authorization can only be amended or rescinded by my written authorization.

_____ _____
Patient Name Date

_____ _____
Patient Signature Date