PERMISION TO DISCLOSE PROTECTED HEALTH INFORMATION
CONSENT AND ACKNOWLEDGEMENT FOR
ETOWAH GASTROENTEROLOGY ASSOCIATES, P.C.

(PLEASE PRINT)

Patient Name: ______________________________ Date of Birth: ______________
Patient Address: ______________________________ SSN: ______________
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I give Etowah Gastroenterology Associates, P.C. permission to release medical information to the follow persons:

☐ None
☐ 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)** ______________________
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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