Print Form

SYRACUSE GASTROENTEROLOGICAL ASSOCIATES, P.C.

CNY Medical Center, 739 Irving Ave, Ste 400, Syracuse, NY 13210 (315) 234-6677
Clay Medical Center, 8100 Oswego Rd, Suite 140, Liverpool, NY 13090 (315) 641-1966

Notice of Privacy Practices and Authorization for Release of Information

Patient Name: _____ Birth Date: _____

- *I authorize Syracuse Gastroenterological Associates, PC to release protected health information, if necessary, about the above-named patient to the people named below.*
- *I understand that Syracuse Gastroenterological Associates, PC may need to discuss my medical condition and may need to share my medical records with any physician, physician extender, nurse, therapist, family member, friend, or other health care provider who is involved in my care.*

Home _____ Cell _____ Work _____

☐ Yes ☐ No SGA may leave messages (for appointment reminders, lab, x-ray, or other test results) on my telephone answering machine at my home.

☐ Yes ☐ No SGA may leave messages (for appointment reminders, lab, x-ray, or other test results) on my telephone voice mail at my work.

☐ Yes ☐ No If necessary, SGA may talk with my parents, family member, friend, or my caretaker about my medical condition (for appointment reminders, lab, x-ray, or other test results) and / or billing information. Please list these people below.

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

- *I am aware that I can obtain a copy of the SGA Patient Privacy Notice in the office or by mail if requested.*
- *I understand that SGA has an automated system that calls to remind me of my appointment and that appointment reminders, lab, x-ray, or other test results may come in the mail to my home.*
- *I understand that I have the right to change this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending written notification. I understand that any change in this authorization is effective from the date signed going forward.*
- *I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.*
- *I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned upon signing. This authorization shall be in effect until revoked by the patient.*

_____ _____
Signature of Patient Date

_____ _____
Signature of Representative Relationship