SYRACUSE GASTROENTEROLOGICAL ASSOCIATES, P.C.

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 _____

SGA may leave messages for appointment reminders, lab, x-ray or other test results; how to participate in patient satisfaction surveys and other important communications:

__Yes __No On my telephone answering service **at my home or cell** as a direct dial call or through the pre-recorded or artificial voice messages and/or the use of an "automated telephone dialing system."

__Yes __No On my telephone voice mail **at work** as a direct dial call or through the pre-recorded or artificial voice messages and/or the use of an "automated telephone dialing system."

__Yes __No By the use of text messages.

__Yes __No By the use of email. (Email _____)

LIST BELOW ANY PERSON(S) THAT WE MAY SPEAK WITH: Please list any (parents, family member, friend, caretaker, or other) that SGA may speak with about your medical condition (including appointment reminders, lab/x-ray/other test results, or messages from the doctor) and/or billing information.

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