G.I. MEDICINE ASSOCIATES P.C.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

The undersigned Patient or legally authorized representative ("Agent") of the Patient acknowledges that he or she personally read the posted G.I. Medicine Associates P.C. Notice of Privacy Policies on the dated indicated below.

Signature: _____Date: _____/_____/20_____

Please Print Name of Patient: _____DOB _____

PERMISSON TO GIVE MEDICAL INFORMATION

I,_____, hereby authorize the physicians and staff of G.I. Medicine Associates P.C. to give information concerning my health and well-being to the following:

	Name	Relationship	Phone #
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

_____Leave Message on answering machine HOME WORK CELL (please circle)

_____I DO NOT authorize the release of my medical information

_____

The following information may be given to the above:

_____Appointments _____Medications

_____Test Results _____Medical History and Treatment

_____ _____ ____/____/20_____

Please Print Patient Name Signature Date

If delay in treatment results because we cannot reach you, G.I. Medicine Associates P.C. will not be held responsible.