

**PLEASE PRINT**

**Confidential Information**

Name

- I. List the persons, including family members or others, who may be informed about your general medical condition and your diagnosis (including treatment, payment, and health care operations):

Name	DOB	Phone	Relation

- II. List the persons, including family members or others, who may be informed about your medical condition **ONLY IN AN EMERGENCY**.

Name	DOB	Phone	Relation

- III. Indicate the address where you would like your billing statements and/or correspondence from my office to be sent, if other than your home address.

- IV. Indicate if you want all correspondence from my office sent in a sealed envelope marked "CONFIDENTIAL":

Yes                  No

- V. Indicate the telephone number where you want to receive calls about your appointments, laboratory and x-ray results, or other health care information, if other than your home phone number:

*/ am fully aware that a cell phone is not a secure and private line.*

- VI. Can confidential messages (e.g. appointment reminders) be left on your telephone answering machine?

Yes                  No

- VII. Can confidential messages (e.g. appointment reminders) be left on your voicemail?

Yes                  No

DATE

SIGNATURE

\_\_\_\_\_

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

**Please print your name here**

*Signature*

*Date*

**FOR OFFICE USE ONLY**

We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- The patient refused to sign
- Due to an emergency situation it was not possible to obtain an acknowledgement
- We weren't able to communicate with the patient.
- Other *(Please provide specific details)*

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*Employee signature*

*Date*

**CONSENT FOR USE / DISCLOSURE OF HEALTH INFORMATION**

Patient's Name:

Patient's Date of Birth:

Patient's SSN:

**Notice to Patient:**

By signing this form, you grant us consent to use and disclose your protected health care information for the purposes of treatment, various activities associated with payment and health care operations. Our Notice of Privacy Practices provides more details on our treatment, payment activities and health care operations. If there is not a copy of the Notice accompanying this Consent form, please ask for one. We encourage you to read it since it provides details on how information about you may be used and/or disclosed and describes certain rights you have regarding your health care information.

As stated in our Notice of Privacy Practices, we reserve the right to change our privacy practices. If we should do so, we will issue a revised Notice. Since revisions may apply to your health care information, you have a right to receive a copy by contacting our Privacy Officer.

You have the right to revoke your Consent by giving written notice to our Privacy Officer. The revocation will not affect actions that were already taken in reliance upon this Consent. You should also understand that if you revoke this Consent we may decline to treat you.

You are entitled to a copy of this Consent Form after you have signed it.

*(To Be Completed by Patient or Patient's Representative)*

I, \_\_\_\_\_ have read the contents of this Consent Form and the Notice of Privacy Practices. I understand that I am giving you my consent to use and disclose my health care information to carry out treatment, payment activities and health care operations.

\_\_\_\_\_  
Patient's Signature or Signature of Patient's Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Patient's Representative

\_\_\_\_\_  
Relationship to Patient

**Our Privacy officer can be contacted as follows:**

Name of Privacy Officer: VALERIE SWEETLAND

Practice Address: 8207 MAIN STREET, SUITE 8, WILLIAMSVILLE, NEW YORK 14221

Phone: 716-632-3577

Fax: 716-631-8275

Email: valerie@maingastro.com

**HIPAA Consent for Use / Disclosure of Health Information**

*This form does not constitute legal advice and covers only federal, not state, law.*