HIPAA/Privacy

I understand that I have a right to review the companies' Notice of Privacy Practices and/or Patient Rights Document prior to signing this document. A copy is available upon request and is available on our website ***www.capegastro.com***. The Notice of Privacy Practices provides information about how the companies may use and disclose protected health information about me. The Patient Rights acknowledges my rights as a patient. We are required by law to maintain the privacy of protected health information. For further information regarding our privacy policy or patient rights document, please contact our administrator, Robyn Crocetti.

_____
Today's Date

_____ _____ _____
Signature of Patient Print Name of Patient Birth Date

_____ _____
Personal Representative/Description of Authority Print Name of Personal Representative

GASTROENTEROLOGY ASSOCIATES OF SOUTHEAST MISSOURI, P.C., AND GA ENDOSCOPY CENTER, LLC ARE AUTHORIZED TO RELEASE MY HEALTH INFORMATION TO THE FOLLOWING:
(Please Print)

1. _____ _____
(Name) (Relationship) (Area Code) (Phone Number)

2. _____ _____
(Name) (Relationship) (Area Code) (Phone Number)

3. _____ _____
(Name) (Relationship) (Area Code) (Phone Number)

4. _____ _____
(Name) (Relationship) (Area Code) (Phone Number)

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