COLON AND RECTAL ASSOCIATES, LTD.

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PATIENT PRIVACY NOTICE and

RELEASE OF MEDICAL/BILLING INFORMATION

BY SIGNING THIS, I ACKNOWLEDGE RECEIPT OF COLON AND RECTAL ASSOCIATES' PATIENT PRIVACY PRACTICES NOTICE (AS PER HIPAA).

You may find a readable copy of the Notice at the reception desk, request a copy of the Notice from the staff, or you may find it at http://www.colonandrectalassoc.com

◊ **If you wish to release your information to anyone, please indicate below. If you do not wish to release your information, please skip this section:**

I, _____, authorize Colon and Rectal Associates and their staff to release information on file regarding my medical treatment, billing information and appointment information to the person(s) listed below:

Name:_____Relationship:_____

Name:_____Relationship:_____

Name:_____Relationship:_____

Name:_____Relationship:_____

◊ **If you do not wish to release your information, please complete the following section**:

I, _____, do not authorize anyone to have access to my billing and medical information.

◊ **Please indicate if we may leave messages as described below**:

I give consent for the office to leave a message or text on my phone, answering machine, voicemail or with my spouse, parent or other household member. Yes___◯___ No___◯___

I give consent for the office to leave results of testing on my answering machine, by text, voicemail, or with a spouse, parent or other household member. Yes___◯___ No___◯___

Patient's Printed Name:_____**Date of Birth:**_____

_____ Patient Signature

_____ Today's Date

By typing your name on the signature line, you agree with the terms and conditions of the document.