www.middlesexgastro.com

Patient Acknowledgment and Consent for Use and Disclosure of Protected Health Information

Name:_____ Date of Birth: _____

How may we contact you?

Home Phone:_____	Cell Phone:_____	Work Phone:_____
☐ DO NOT leave a message	☐ DO NOT leave a message	☐ DO NOT leave a message
☐ Leave a brief message, return #	☐ Leave a brief message, return #	☐ Leave a brief message, return #
☐ May leave a detailed message.	☐ May leave a detailed message.	☐ May leave a detailed message.

I CONSENT to Middlesex Gastroenterology Associates, LLC (MGA) discussing any or all of my personal medical information including my evaluation, treatment, diagnosis even if related to psychiatric or psychosocial impairments, substance abuse, acquired immunodeficiency virus (HIV), HIV-related opportunistic infections, or pregnancy with the following person(s):

1._____ Relationship:_____ Phone Number:_____

2._____ Relationship:_____ Phone Number:_____

3._____ Relationship:_____ Phone Number:_____

4._____ Relationship:_____ Phone Number:_____

To better provide for your care and enhance your patient experience, we seek to coordinate and integrate our care delivery through our electronic medical records (EMR) which is paperless. We share access to the EMR across our practice locations (accessed only as described in the Notice of Privacy Practices).

I hereby acknowledge that I have received a copy of the Notice of Privacy Practices for Middlesex Gastroenterology Associates, LLC (MGA). I further acknowledge that a copy of the current notice will be posted in the reception area, and that I may request a copy of any amended Notice of Privacy Practices at each appointment.

Signed:_____ Date:_____

Print Name:_____

Telephone:_____

If not signed by the patient, please indicate your relationship to the patient:_____

For Office Use Only:

☐ Signed form received by:_____

☐ Acknowledgement refused:

Efforts to obtain: _____

_____

Reasons for refusal: _____

_____