Brandywine GI Associates

PATIENT DISCLOSURE AUTHORIZATION (HIPAA)

With your permission, we can provide information to you in a variety of ways.

Please indicate agreement with the following list by checking all that apply:

DATE: _____

PATIENT NAME: _____ _____

Printed Signature

_____ It is acceptable for you to leave information on my voice mail/answering machine, including appointment reminders.

Phone Number _____

_____I do not want you to speak with any family members or friends regarding my condition.

_____ It is acceptable for you to speak with only the following family member/friends regarding my condition. (Please check all that apply)

_____ Spouse (please indicate name _____)

_____Sibling (please indicate name_____)

_____Children (please indicate name_____)

_____Friend (please indicate name_____)

_____Other (please indicate name_____)

Any additional person, please list on back of form.

It is the patient's responsibility to notify the office staff of any changes to this authorization.