New Patient Form

Consent for Release of Confidential Information

Hattiesburg GI Associates
powered by GI Alliance

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CONSENT

I,_____hereby give my consent to Hattiesburg GI Associates, PLLC and Digestive Diseases Center of Hattiesburg to use or disclose, for the purpose of carrying out treatment, payment or health care administration, all information contained in the patient record of:

Patient's Name: _____Date of Birth_____

I understand that employees of Hattiesburg GI Associates, PLLC and Digestive Diseases Center of Hattiesburg will keep communications regarding my health information confidential.

Please adhere to the following communication preferences:

1. Phone: You can contact me by phone at the current phone numbers on file.
   - Leave confidential messages on answering machine. _____Yes _____No
   - Leave confidential messages with any other person. _____Yes _____No
   - You can speak to a family member or representative who calls on my behalf _____Yes _____No

If yes to leaving a message or speaking with another person, please name who we can leave a message with or receive a call from:

Name:_____Phone #_____Relationship to Patient:_____

Name:_____Phone #_____Relationship to Patient_____

Name:_____Phone #_____Relationship to Patient_____

Name:_____Phone #_____Relationship to Patient_____

Name:_____Phone #_____Relationship to Patient_____

1. _____ Mail: Contact me at the current address on file
2. _____ E-Mail: Contact me at the current email address on file.
3. _____ Other requests for confidential communication:

Signature_____Date_____

OFFICE USE ONLY

Patient's Name: _____Chart Number:_____

Entered into gGastro By: _____ _____ Date:_____