



**PERMISSION TO DISCLOSE PROTECTED HEALTH INFORMATION
 CONSENT AND ACKNOWLEDGEMENT
 FOR BIRMINGHAM GASTROENTEROLOGY ASSOCIATES, P.C.
 205-271-8000 • 205-879-7061 Fax**

(PLEASE PRINT)

Patient Name _____ Date of Birth: _____

Patient Address _____ SSN: _____

I give Birmingham Gastroenterology Associates, P.C. permission to release medical information to the following people:

- None
- Parents _____ Spouse _____
- Father (only) _____ Mother (only) _____
- Other _____ Guardian _____

I wish to be contacted in the following manner by Birmingham Gastroenterology Associates, P.C. (check all that apply):

- Home Telephone** _____ **Written Communication**
 - O.K. to leave message with detailed information
 - Leave message with call back number only
- Work Telephone**
 - O.K. to leave with detailed information
 - Leave message with call back number only
- Other (Email address)** _____

The Privacy Act generally requires healthcare providers to take responsible steps to limit the use of disclosure of and requests for protected health information to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of protected health information disclosures. Information provided below, if completed properly, will constitute an adequate record.

Consent:

I consent to the use and disclosure of protected health information about me by my physician and my physician's practice for purposes of treatment, payment, health care operations, protection of others and disclosures required by law, including information about notifiable diseases, sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS) and human immunodeficiency virus (HIV).

NOTE: Uses and disclosures for protected health information may be permitted without prior consent in an emergency.

ACKNOWLEDGMENTS:

I acknowledge that I have received Birmingham Gastroenterology Associations, P.C. Notice of Privacy Practices.

 Signature of Patient or Personal Representative

 Date

 Relationship of Personal Representative to the Patient

 Signature of Witness

 Print Personal Representative's Name