www.connecticutgi.org

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 message, return #	☐ Leave a message, return #	☐ Leave a message, return #
☐ May leave a detailed message.	☐ May leave a detailed message.	☐ May leave a detailed message.

☐ By checking this box you agree to receive text messages from Connecticut GI, PLLC. You can reply stop to opt-out at any time. Please reference our SMS Privacy Policy for additional questions: https://www.connecticutgi.org/patient-forms/

Do you have an appointed individual who is legally authorized to act on your behalf under the requirements of a valid Power of Attorney (POA) or similar legal designation? Yes _____ No _____
If yes, please list Name, Relationship and Phone Number:_____

- Please provide a copy of the legal document for our records.

I CONSENT to CT GI P.C. 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 #:** _____
2. _____ **Relationship:** _____ **Phone #:** _____
3. _____ **Relationship:** _____ **Phone #:** _____
4. _____ **Relationship:** _____ **Phone #:** _____

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 Connecticut GI, PLLC. 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: _____

Reason for refusal: _____