Gastro Health /Middlesex Endoscopy Center

Consent to Disclose Health Information for Payment, Treatment, and Health Care Operations

These records will be transferred to Electronic Medical Records through Emerson Hospital

Patient Name: ____
Last First Middle

Home Address: ____
Street Town State Zip

Date of Birth: ______________________ **Gender:** ______________________

Home Telephone: ______________________ **Cellular Telephone:** ______________________

Emergency Contact: ______________________ **Relationship to Patient:** ______________________

Emergency Contact Telephone: ______________________ **For Tricare – Sponsor's SSN:** ______________________

****Provide e-mail address if you would like **Emerson Portal** access:

Email address: ____

Primary Insurance: ______________________ **Primary Care Physician:** ______________________

Secondary (If any): ____

How would you like to receive reminders? (circle one) Text Phone Call or Email

Are we authorized to discuss your appointments, test results, and other pertinent health information with another person?(i.e. spouse, sibling, parent) ☐ **Yes** ☐ **No**

If yes, who: ______________________ Relationship to patient: ______________________

Acknowledgment of Receipt of Practice's Notice of Privacy Practices:

By my signature below, I hereby acknowledge that I have received a copy of the Practice's Notice of Privacy Practices.

Consent to Disclose My General Health Information:

By my signature below, I hereby authorize the Practice to disclose my medical information so that the Practice may treat me, seek payment from third parties for such treatment, and generally carry on the Practice's health care operations (e.g., quality assurance). I also authorize the Practice to disclose my medical information to insurers and providers outside of the Practice when necessary so that these providers may treat me, seek payment for that treatment, and for the purpose of their health care operations. I also understand that my refusal to sign this consent or revoking this consent may lead to refusal of treatment as permitted by Section 164.506 of the Code of Federal Regulations.

______________________________ ______________________
Signature of Patient Date

If the patient is an unemancipated minor or otherwise incapacitated (physically or mentally), obtain the following signatures:

______________________ ______________________ ______________________
Signature of Personal Representative Description of Authority Date

***For Office use only: ID (License has been checked) ☐ ***

PLEASE ENCLOSE A COPY OF YOUR INSURANCE CARD

In order to protect your identity we request that you bring a valid picture ID and your insurance card to your visit.