

AUTHORIZATION FORM

The Health Insurance Portability and Accountability Act

The Health Insurance Portability and Accountability Act (HIPAA) calls for security standards protecting the confidentiality and integrity of individually identifiable health information.

Our Notice of Privacy Practices provides information regarding how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You may obtain a copy of the current policy on the Practice’s website at www.ncdhp.com. By signing below, I acknowledge that I have been offered a copy of Digestive Health Partners’ Notice of Privacy Practices.

I understand that I have the right to request restrictions on how my medical information is used or disclosed and that I may revoke this acknowledgement at any time in writing.

HIPAA standards prohibit us from leaving messages with test results and other medical information without your authorization. **Please choose one of the following options:**

- YES**, I authorize the physicians and staff of Digestive Health Partners to leave detailed health-related information or appointment reminders via voice and/or text message, email or fax.
- NO**, do not leave detailed health-related information or appointment reminders via voice and/or text message, email or fax.

Only you and individuals you name below will have access to your medical records. I authorize physicians and staff of Digestive Health Partners to release information pertaining to my condition and/or care to those individuals listed below:

Name	Relationship	Contact Phone Number

WE CANNOT SPEAK TO ANYONE YOU HAVE NOT LISTED ABOVE.

A COMPLETED AND SIGNED FORM IS REQUIRED FOR LEGAL AUTHORIZATION

By signing below, I understand that I have the right to request restrictions on how my medical information is used or disclosed and that I may revoke this acknowledgement at any time in writing. I also confirm that I have been offered a copy of the Patient Rights and Responsibilities form.

Patient Print Name: _____ Date of Birth: _____

Patient or Responsible Party Signature: _____ Today’s Date: _____

If Legal Representative, Print Name & Relationship to Patient: _____