Amarillo Colon and Rectal Clinic

PATIENT HIPAA ACKNOWLEDGMENT AND AUTHORIZATION TO RELEASE PERSONAL HEALTH INFORMATION (PHI)

I have been given a copy of Amarillo Colon and Rectal Clinic, P.A.'s Notice of Privacy Practices. I consent to the disclosures of my health information as outlined in the Notice.

_____ _____

Signature of Patient or Representative Date

_____ _____

Print Name Relationship of Representative or Patient

Authorization to release PHI to family members, friends, caretakers
YOU MAY REFUSE TO SIGN BELOW

By signing below you acknowledge and agree that Amarillo Colon and Rectal Clinic may use or disclose Protected Health Information to the persons you write below. **This information will include Voicemail messages, Billing information, and Lab Results unless our office is otherwise notified.**

Full Name (printed)	Date of Birth	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____

_____ _____ _____

Signature (patient/patient representative Date Relationship to Patient

_____ _____

Full Name (Print) Date of Birth

Date: Expiration Date 1 year unless otherwise specified