

**Middlesex Gastroenterology, P.C.**

**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: \_\_\_\_\_

Primary Insurance: \_\_\_\_\_ Primary Care Physician: \_\_\_\_\_

Secondary (If any): \_\_\_\_\_

**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. (Included on the back of this page ).

**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

Yes No

Are we authorized to discuss your appointments, test results, and other pertinent health information with another person?(i.e. spouse, sibling, parent)

If yes, who: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

**\*\*\*PLEASE ENCLOSE A COPY OF YOUR INSURANCE CARD\*\*\***