GI Associates & Endoscopy Center
powered by GI Alliance

ClearAll-PHI

Uses and Disclosures of PHI

Patient Name: _____ Birth Date: _____

1. ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received the _____ ("Practice") HIPAA Notice of Privacy Practices. By signing below, I consent to the uses and disclosures described under the heading: "**Uses and Disclosure of PHI that Do Not Require an Authorization.**" Other uses and disclosures will require a separately signed authorization unless otherwise permitted by law. If I have a question or complaint, I understand that I may contact the Practice by phone at 1-877-373-1630 or by email at complianceGIA@gialliance.com.

2. DISCLOSURES TO FRIENDS AND/OR FAMILY MEMBERS

If you would like the Practice to share protected health information about your care with your friends or family members, please list the individual(s) who may receive your information below.

Name: _____ Phone Number: _____

Name: _____ Phone Number: _____

Name: _____ Phone Number: _____

By signing below, I agree to each of the above items (Section 1 and Section 2).

_____ _____

Signature Date

_____

Printed Name of Patient

If signed by patient's representative, description of authority (such as parent/guardian):

_____