Release of Information

ATL Colorectal Surgery, P.C. is committed to protecting the privacy of our patients. Therefore, we will not give test results, medical information, financial information, or other private health information to anyone other than the patient, guardian, or referring doctor, nor leave messages about test results on voicemail or an answering machine without your permission.

Please indicate your preferences below:

You may contact me at the phone number(s) listed below with test results. I have checked the number I prefer you call. ***If no numbers are listed, we will only call the home number listed in our records.*** ***Note:*** *(reminder calls about appointments will be left on answering machines or voice mail by our automated system)*

☐ Home ______________________________ ☐ Work ______________________________

☐ Cell ______________________________ ☐ Other ______________________________

Yes No You may leave a message on my answering machine or voice mail

Yes No You may provide private health information about me (or the patient) as indicated below (information will be provided only to those listed):

Name	Relationship	Information to provide	
		☐ **Medical**	☐ **Financial**
		☐ **Medical**	☐ **Financial**
		☐ **Medical**	☐ **Financial**

Yes No You may text me appointment reminders at: ______________________________

Yes No You may email me appointment reminders at: ______________________________

Under HIPAA regulations, we may provide private health information to other healthcare entities involved in your care and insurance companies for billing purposes without your written permission.

By signing this form, I understand that the information provided above supersedes all previous notifications and will remain in force until I provide different written instructions.

Patient or guardian signature ________________________ **Date signed** ____________

Printed patient name ________________________________

Relationship of guardian (if applicable) ____________________________