

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

Email address: \_\_\_\_\_ \*\*\*\* provide e-mail address if you would like **Emerson Portal** access

Preferred Pharmacy: \_\_\_\_\_

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

How would you like receive reminders? (circle one) Text, Phone Call, or Email

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: \_\_\_\_\_

**Acknowledgment of Receipt of Practice’s Notice of Privacy Practices:**

By my signature below, I hereby acknowledge that I have viewed a copy of the Practice’s Notice of Privacy Practices, on the precheck Clearwave system, which can be printed or requested to be printed for you.

**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

\*\*\*For Office use only: ID (License has been checked)  \*\*\*

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

**\*\*\*In order to protect your identity we request that you bring a valid picture ID and your insurance card to your visit.\*\*\***