COLON AND RECTAL ASSOCIATES, LTD.

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A. PATIENT PRIVACY NOTICE

BY SIGNING THIS, I ACKNOWLEDGE RECEIPT OF COLON AND RECTAL ASSOCIATES' PATIENT PRIVACY PRACTICES NOTICE (AS PER HIPAA).

(You may find a readable copy of the Notice at the reception desk, request a copy of the Notice from the staff, or you may find it at www.colonandrectalassoc.com)

Patient's/Guardian's Printed Name: _____

Patient's/Guardian's Signature: _____ Date_____

B. RELEASE OF MEDICAL and BILLING INFORMATION

I, _____, authorize Colon and Rectal Associates and their staff to release information on file regarding my medical treatment, billing information and appointment information to the person(s) listed below:

Name:_____ Relationship:_____

I, _____, do not authorize anyone to have access to my billing and medical information.

I understand that by signing this release, the designated person(s) above will be able to speak to any member of Colon and Rectal Associates' staff. Furthermore, I understand the physician's office cannot be held liable for any information the above stated person(s) may obtain regarding my medical care or my account and/or appointments.

Patient's/Guardian's Printed Name: _____

Patient's/Guardian's Signature: _____ Date:_____

I give consent for the office to leave a message or text on my phone, answering machine, voicemail or with my spouse, parent or other household member. Yes No

I give consent for the office to leave results of testing on my answering machine, by text, voicemail or with a spouse, parent or other household member. Yes No