inSite
DIGESTIVE HEALTH CARE

Consent to Disclose Patient Health Information to Family and Friends/Authorization to Leave Results Message

Patient Name: _____ Date of Birth: _____

I understand that inSite Digestive Health Care (formerly known as Southern California Gastroenterology Associates) or any of their affiliated physicians will NOT disclose my protected health information to my family, friends or relatives except in emergency situations.

I understand that inSite Digestive Health Care (formerly known as Southern California Gastroenterology Associates) or any of their affiliated physicians may disclose my protected health information to my family, friends or relatives that I identify as an entity directly involved in my care or payment of my care. I understand that I have the opportunity to agree or object to such disclosure.

The individual(s) named below is/are directly involved in my care and I would like these individuals to give and receive information from my physician or inSite Digestive Health Care (formerly known as Southern California Gastroenterology Associates) regarding my medical condition and treatment. Therefore, I hereby consent, agree and authorize inSite Digestive Health Care (formerly known as Southern California Gastroenterology Associates) and my physician to disclose my protected health information to the following individual(s):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

_____ **Initial here if we may leave a message on your answering machine/voicemail with results.**

Phone Number _____

I understand that by consenting to the disclosure of my protected health information to the individual(s) named above, all my personal information relevant to my care and treatment may be disclosed including, but not limited to, my medical history, my medical condition, diagnostic test results, laboratory results, surgical procedures and other personal information given to, or discussed with, my physician at his medical office.

This consent is effective immediately and shall remain in effect until I revoke it. I understand that I have the right to revoke this consent at any time by providing written notice to inSite Digestive Health Care at the following address: 225 W. Broadway, Suite 350, Glendale, CA 91204. I further understand that I am NOT required to sign this form in order to receive treatment, and that I am voluntarily requesting and consenting to disclose my protected information to the individual(s) named above.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____