AGC
Athens Gastroenterology Center, P.C.
21 Jefferson Place · Athens, Georgia 30601

Patient Disclosure Form

In general the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information. You are also provided the right to request confidential communications or that a communication of protected health information is made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (Please check all that apply)

	Home Telephone #		Work Telephone #		Written Communication
	Ok to leave message with detailed information		Ok to leave message with detailed information		O.K to mail to my home address
	Leave message with call back number only		Leave message with call back number only		O.K. to mail to my work/office
					O.K. to fax to this number

_____ _____

Patient Signature **Date**

_____ _____

Print Name **Date of Birth**

We at Athens Gastroenterology Center value and do everything in our power to protect your privacy. Your medical information will not be given to any individual (Including spouses, parents, children, or any significant others without your written consent). If you want anyone other than your referring physician to have access to your medical information please list their name, address, relation, and phone number below.

Note: Uses and disclosures may be permitted without prior consent in an emergency.

Name	Address	Telephone	Relation