New Patient Form

Consent for Release of Confidential Information
And Receipt of Privacy Practices

I,____hereby give my consent to GI Alliance of Illinois to use or disclose, for the purpose of carrying out treatment, payment or health care administration, all information contained in the patient record of:

Patient's Name: ____Date of Birth____________________

I understand that employees of GI Alliance of Illinois will keep communications regarding my health information confidential.

Please adhere to the following communication preferences:

1. Phone: You can contact me by phone at the current phone numbers on file.
   - Leave confidential messages on answering machine. ______Yes ______No
   - Leave confidential messages with any other person. ______Yes ______No
   - You can speak to a family member or representative who calls on my behalf ______Yes _____No

If yes to leaving a message or speaking with another person, please name who we can leave a message with or receive a call from:

Name:________________________________Phone #_____________________Relationship to Patient:____________

Name:________________________________Phone #_____________________Relationship to Patient_____________

1. ___________ Mail: Contact me at the current address on file
2. ___________ E-Mail: Contact me at the current email address on file.
3. ___________ Other requests for confidential communication:

I acknowledge receipt of the physician's Notice of Privacy Practices. The Notice of Privacy Practices provides detailed information about how the practice may use and disclose my confidential information. I understand that the physician has reserved the right to change his or her privacy practices that are described in the notice. I also understand that a copy of any revised notice will be provided to me or made available to me in a reasonable period of time in writing. I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so to the physician. I also understand that I will not be able to revoke this consent in cases where the physician has already relied on it to use or disclose my health information. Written revocation must be sent to the physician's office.

Signature____Date______________________________