



Dr. Simon Cofrancesco  
GI North, P.C.

## Patient Acknowledgement Form

Patient Name: \_\_\_\_\_

Please Print

When you visit the practice, it is very important that you feel safe in telling your physician personal information that may be required to fully diagnose or treat a problem. The practice has strict policies and procedures to protect the confidentiality of the information that you have entrusted to us. The Health Insurance Portability and Accountability Act (HIPAA) rules require that the practice provide all of our patients with the attached Notice of Privacy Practices on their first visit. The notice describes how the medical information we receive from you may be used or disclosed by the practice and your rights related to your access to this information. Please sign below that we have provided you with a copy of our notice to review. If you have any questions about our Privacy Practices, please feel free to contact our Privacy Officer. Thank you for your cooperation.

*Please tell us how to contact you to discuss your medical care.*

It is our policy to not release a patient's confidential and/or unauthorized information by telephone or voicemail except for appointment confirmation. Whenever returning phone calls, we do not leave a message in voicemail if the name or telephone number is not on the recorded message to identify the residence. Information will not be left with an unauthorized person who may answer the telephone. If you would like to have information released to someone other than yourself, please complete the following:

*I authorize GI North, P.C to leave medical information pertaining to my care by the following methods and will assume responsibility to notify the practice, in writing, whenever this information changes.*

Home Phone: Yes \_\_\_ No \_\_\_ Cell Phone: Yes \_\_\_ No \_\_\_ Voicemail/Machine: Yes \_\_\_ No \_\_\_

Work Phone: Yes \_\_\_ No \_\_\_ Pager: Yes \_\_\_ No \_\_\_ Email: Yes \_\_\_ No \_\_\_

May we fax medical records for referrals? Yes \_\_\_ No \_\_\_

Please list names of people with whom we can discuss your medical care:

Spouse Name: \_\_\_\_\_ Parent Name: \_\_\_\_\_

Other Name (s) & Relationship: \_\_\_\_\_

Please list a unique identifier as a way to confirm your identity when calling the office. This unique identifier must be given before any information can be disclosed.

Unique Identifier: \_\_\_\_\_

(last 4 digits of your social security # or mother's maiden name)

*I also acknowledge that I have received a copy of the Practice's Notice of Privacy Practices and have been given an opportunity to ask questions.*

Signature of patient or personal representative:

\_\_\_\_\_ Date: \_\_\_\_\_

Personal representative, give relationship to patient: \_\_\_\_\_