PRIVACY PRACTICES ACKNOWLEDGMENT & CONSENT

A copy of The Notice of Privacy Practices for Hillside Gastroenterology & Nutrition, Inc. is readily available at our office upon your request.

Hillside Gastroenterology & Nutrition, Inc. is authorized to use and disclose health information about _____ (patient name) for treatment, payment, and healthcare operation purposes consistent with its Notice of Privacy Practices.

*_____ *_____

Signature of Patient (or Personal Representative) | Date

_____ _____

Name of Personal Representative (if applicable) | Relationship to Patient

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AUTHORIZATION TO USE AND/OR DISCLOSE HEALTH INFORMATION

This authorization gives Hillside Gastroenterology & Nutrition, Inc. permission to use and/or disclose health information about you to those specified by you. You have the right to revoke authorization at any time.

Please list ANY/ALL persons with whom we may discuss your health information. DO NOT include insurance carrier or other physicians.

Name	Relationship	Telephone	Birth Date