Downriver Gastroenterology, P.C.
Frank Singh, D.O.

HIPAA PRIVACY

Name: _____ Date of Birth: ___/___/_____

Release of Information

☐ I give my consent to the entire staff of Downriver Gastroenterology, P.C. permission to release my lab/test results, referrals, medication request and telephone inquiries regarding all and any treatment relating to myself. In addition to my physician(s) and insurance company(ies), this may be released to the following individuals:

☐ Spouse/Partner_____

☐ Child(ren) _____

_____

_____

☐ Other _____

☐ Information is not to be released to anyone.

Patient Signature: _____ Date: ___/___/_____

Updated:

Patient Signature: _____ Date: ___/___/_____

Patient Signature: _____ Date: ___/___/_____

A copy of Notice of Privacy Practices is available on our website: downrivergastro.com or in our office upon request.

DOCUMENTATION OF FAILURE TO OBTAIN SIGNED ACKNOWLEDGMENT

On _____, 20___ presented this Acknowledgement of Receipt of Notice of Privacy Practices Form

to _____ (the patient). The patient refused to provide a signature when requested.