Southern Gastroenterology Specialists, P.C./ G I Endoscopy Center/ Locust Grove Endo Center is a healthcare provider and will share my health information for treatment, payment, and healthcare operations, including to my primary care physician. I have been provided access to the Notice of Privacy Practices that describes how my health information is used and shared. I also have access to a copy of these rights to retain for my records. I understand that Souther Gastroenterology Specialists/ G I Endoscopy Center/ Locust Grove Endo Center has the right to change this notice at any time. I may obtain a current copy by contacting the Privacy Officer, Dr.Jay Prakash, at 770-692-0100 ext 101. or Administrator @404-641-3345

My signature below constitutes my acknowledgement that I have been provided access to the Notice of Privacy Practices. I hereby authorize Southern Gastroenterology Specialists, P.C.and its prividers, permission to use electronic prescriptions and to receive the past and current medication information from the electronic data bases.

_____

Patient/Legal Guardian/Relative Signature If not signed by patient, relationship to Patient

If any person is physically unable to provide a signature OR signs with a mark, print his/her name on the appropriate line above and record the signatures of two responsible persons who witness that such person understands the nature of this acknowledgement on the line below.

_____

Witness #1 Witness#2

If the patient/resident is not capable of acknowledging the notice because of age or medical condition, complete the following:

Patient/resident is a minor(____years of age)OR Patient/resident is unable to acknowledge because_____.

____I authorize Southern Gastroenterology Specialists, P.C/ G I Endoscopy Center/ Locust Grove Endo Center to leave a message on my answering machine/voicemail with test results and financial information.

____I authorize Southern Gastroenterology Specialists, P.C/ G I Endoscopy Center/ Locust Grove Endo Center to have conversations pertaining to my Protected Health Information in front of anyone who accompanies me into the exam room.

____I authorize Southern Gastroenterology Specialists, P.C/ G I Endoscopy Center/ Locust Grove Endo Center to include the following person(s) in my conversations regarding my Protected Health Information:

_____

Names Relationships

_____

Signature of Patient Date