GASTROINTESTINAL ASSOCIATES OF NORTHEAST TENNESSEE AND ENDOSCOPY CENTER OF NORTHEAST TENNESSEE, PC

PERMISSION TO GIVE MEDICAL INFORMATION

I, _____ hereby authorize the physicians and staff of Gastrointestinal Associates and Endoscopy Center of Northeast Tennessee, PC to give the following named individuals information concerning my health and well-being:

NAME	RELATIONSHIP	Phone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____

The following information may be given to the above individuals:

☐ **Checking here give my consent for all items listed below.**

Or

(Individually check for each that you consent)

_____ Test/Lab Results

_____ Pathology Results

_____ Procedure Results

_____ Procedures

_____ Mental Health History

_____ Alcohol/Drug Abuse History

_____ Communicable Diseases (Including but not limited to HIV and AIDS)

_____ Any other information relating to my health not listed (i.e. appointments, prescriptions, etc.)

☐ **I give permission for information from this office to be left on my answering machine and/or voice mail system, as well as the answering machine and/or voicemail system of the above named person(s).**

I understand that I may revoke this consent at any time by giving written notice to our organization.

Signed: _____ Date: _____

(Patient/Parent/Legal Guardian)

Witness: _____ Date: _____