Connecticut Gastroenterology Associates, PC.

Confidential Channel Communication Request

As required by the Health Insurance Portability and Accountability Act of 1996 you have a right to request that communications concerning your personal health information be made through confidential channels. This medical practice will not ask you why you are making your request, and will make reasonable efforts to accommodate all reasonable requests. Some method of contact must be provided

I give Connecticut Gastroenterology Associates, PC. Permission to contact me and/or the individual(s) I designate below regarding my personal medical information.

Please select all that apply. Where you list more than one communication option, please indicate which you prefer.

Phone __ Tel # _____

Do __ Do not__ leave messages on my answering machine

Mail __ address: _____

Other _____

Please feel free to **share my personal medical information** with the individuals I've designated below:

1. Name: _____

   Relationship to patient: _____Contact phone# _____

2. Name: _____

   Relationship to patient: _____Contact phone# _____

Patient Name (Please print): _____Date of Birth _____

Patient Signature: _____Date: _____

If not signed by the patient, please indicate your relationship to the patient: _____