SOUTHWEST ENDOSCOPY & SURGERY CENTER

Southwest Endoscopy and Surgery Center
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Website: www.swgiclinic.com

Notice of Privacy/ Communication Authorization Form

Print Name:_____SS#_____

I have been given the opportunity to read and/or take a copy of the Southwest Endosocopy and Surgery Center Privacy Policies.

When it comes to your medical treatment, we strive to communicate with you in a timely and professional manner. On occasion, family members, friends, or others might be involved in your care. As a patient, you will want our staff to be able to communicate directly with them. In order to protect the privacy of your personal health information, please share with us the names of those individuals with whom we can discuss your care and share your protected health information.

Name:_____

Relationship to patient:_____

Name:_____

Relationship to patient:_____
Name:_____

Relationship to patient:_____

I authorize the surgeon and/or anesthesiologist providing my care to discuss the details of my procedure with immediate family members or the people accompanying me to the facility.

Call Back: (Please check one)

- Speak to me only
- May leave a message on machine
- May speak with:_____

Phone:

Home:_____Cell:_____Work:_____

Patient's Signature:_____Date:_____