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Digestive Care Physicians, LLC

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PATIENT COMMUNICATION CONSENT FORM

In compliance with federal law, it is the policy of Digestive Care Physicians, LLC to **NOT** release confidential, personal, and/or unauthorized information by home telephone, answering machine, work telephone, voice mail, cellular telephone, pager and/or fax. We will not leave a message on an answering machine where the recorded message does not identify the name or number called. Information will not be left with an unauthorized person who may answer your telephone.

I authorize Digestive Care Physicians, LLC to leave medical information pertaining to my care by the following methods and will assume responsibility to notify Digestive Care Physicians, LLC whenever this information changes.

Please list authorized numbers:

Home Telephone: _____
Answering Machine: _____
Work Telephone: _____
Voice Mail: _____
Cellular Telephone: _____
E-Mail Address: _____

I authorize Digestive Care Physicians, LLC to leave medical information pertaining to my care to the following person/persons and will assume responsibility to notify Digestive Care Physicians, LLC whenever this information changes.

Please list authorized names and numbers:

Spouse/Significant Other: _____
Parent: _____
Brother/Sister: _____
Son/Daughter: _____
Friend: _____

PRIVACY PRACTICE ACKNOWLEDGMENT

I have received a copy of the Digestive Care Physicians, LLC, Notice of Privacy Practices.

X _____
Patient Signature / Social Security Number

Date: _____

X _____
Guardian Signature (if patient is under 18)

Date: _____