My signature below confirms that I was notified prior to my procedure at the Eastside Endoscopy Center LLC:

1. Rights and Responsibilities
2. Policy on Advanced Directives
3. Privacy Agreement
4. Ownership Disclosure

_____ _____

Patient Signature Date

PRIVACY CONTACT INFORMATION

May we contact you at: ☐ Home ☐ Ok to leave message

(Check all that apply) ☐ Cell ☐ Ok to leave message

☐ Mail ☐ Home _____

_____

_____

(Address)

Do you authorize release of personal health information to anyone other than yourself?

If so, please List:

Name Relationship to you

_____ _____

_____ _____

_____ _____

I have received my health information rights, and I understand how my personal health information may be used by the Eastside Endoscopy Center, LLC, for matters relating to my case, such as submitting charges.

_____ _____

Signature of patient Date

_____ _____

Witness Date