DIGESTIVE SPECIALISTS, P.A.

Abraham Winkelstein, MD, MS, FACP, FACG ~Anna M. Gonzales, MD ~
A. Tarkan Dural, MD, FACG ~ Edward S. Xavier, MD

Patient Name_____ Date of Birth_____

PREFERRED PHONE NUMBER (____)_____
OK to leave message on machine with detailed message

PREFERRED EMAIL _____
By providing e-mail address, I agree to receive medical information via secure patient portal.

In accordance with the Medical Privacy Act of Texas, the physicians and/or staff of Digestive Specialists, P.A. are unable to release any information pertaining to your condition, treatment and/or care without your consent. If you authorize us to release information regarding your care to anyone other than yourself, please complete the following authorization.

I hereby authorize the physicians and/or staff of Digestive Specialists, P.A. to release information pertaining to my condition and/or care to the individuals listed below.

Name Relationship

Name Relationship

Signature of Patient or Patient's Representative Date

CONSENT FOR RELEASE OF INFORMATION

I hereby acknowledge that I received a copy of the Notice of Privacy Practices. I authorize Digestive Specialists P.A. to use and/ or disclose my health information for treatment, payment, and health care operations.

Signature of Patient or Patient's Representative Date

FINANCIAL POLICIES

I acknowledge that I received and understand the terms and conditions set forth in the Digestive Specialists P.A. Financial Policies.

Signature of Patient or Patient's Representative Date

Revised 2/18/15