Gastrointestinal Specialists of Miami, Inc.

COMMUNICATION OF HEALTH INFORMATION AUTHORIZATION AND APPOINTMENT REMINDER

(PLEASE PRINT)

Last, First Name: _____ Middle Initial: _____

Date of Birth: _____

I _____ authorize

Gastrointestinal Specialists of Miami, Inc. to contact me via the following methods:

PLEASE COMPLETE THE SECTION BELOW. BY CHECKING THE BOXES YOU ARE AUTHORIZING GASTROINTESTINAL SPECIALISTS OF MIAMI, INC. TO CONTACT YOU VIA THE CHOSEN BOXES.

WAYS TO COMMUNICATE HEALTH INFORMATION	**LEAVE MESSAGE ON ANSWERING MACHINE OR VOICEMAIL**	**LEAVE MESSAGE WITH ANY PERSON WHO ANSWERS THE PHONE**
Home Telephone Number: ( )	_____ Yes _____ No	_____ Yes _____ No
Cell Phone Number: ( )	_____ Yes _____ No	_____ Yes _____ No
Other Phone Number: ( )	_____ Yes _____ No	_____ Yes _____ No

Unless otherwise requested, we may remind you of an upcoming appointment by a telephone call, a message on your answering machine or voicemail, or a message with the person who answers your telephone. Appointment reminders will include date and time of your appointment, the provider you are scheduled to see and the medical center location. I understand that this will also authorize the release of my information according to the manner stated above. I understand a written notification is necessary to cancel this request.

Patient Signature: _____

Date Signed: _____