Digestive Diseases Specialists of Colorado

Pueblo Endoscopy Suites

Disclosure of Personal Health Information (PHI)

- We will NOT leave messages with anyone expect the patient or the legal guardian.
- We will NOT leave health information on the answering machine.
- We will NOT leave any health information on voicemail.

UNLESS WE HAVE YOUR WRITTEN PERMISSION TO DO SO

Please read below and let us know what you prefer

I give Digestive Diseases Specialists of Colorado and Pueblo Endoscopy Suites, my permission to leave phone messages regarding my medical care and test results with individuals listed below. I understand that information will not be released to any individuals not listed below.

My cell voicemail:	Initials:	_	
My home answering machine:	Initials:	<u> </u>	
My office/work voicemail:	Initials:		
My spouse:	Initials:		
Other:	Initials:		
I would like to receive automated app	ointment reminders via:	voice message	text message
Please list who you give	us permission to talk to	regarding your me	edical care.
Personal Health Information			
I hereby give my consent to DDS/PE and healthcare. The notice of privacy	practices provided describ	•	2 0
the right to review prior to signing thi	.s consent.		
Patient name:			
Signature:		Date: _	
Parent or Guardian Signature:			