Colon & Rectal Surgical Associates • Division of Surgical Specialists of New Jersey, LLC
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Due to the **HIPAA Compliance Privacy Laws of the Federal Government**, it is mandatory that we ask you to review and answer the following questions listed below.

NAME: ____

May we leave messages/detailed medical information on voicemail at either of these phone numbers?

☐ **YES** ☐ **NO** Home Phone: __________________ ☐ **Yes** ☐ **NO** Cell Phone: ___________________

May we contact you at your place of employment? ☐ **YES** ☐ **NO** If so, may we leave a message? ☐ **YES** ☐ **NO**

If yes: Work Phone: ____________________ Extension: ______________

Do you have any particular person you wish to designate as your representative regarding surgical scheduling, receipt of medical information or billing issues? ☐ **YES** ☐ **NO**

If so, please provide: Name: ___________________________ Relationship: ________________________

Phone Number: ________________________ Alternate Number: _________________________

I hereby authorize **Colon & Rectal Surgical Associates** to obtain or release any and all pertinent information regarding my medical care, as needed, to assist in my ongoing treatment to or from other health care providers, laboratories, radiology facilities or other institutions. **This authorization remains in effect until revoked.**

I have reviewed the aforementioned information and provide my consent regarding any and all the issues as stated above.

SIGNATURE:______________________________________ DATED: ________________

WITNESSED BY: __________________________________