



Carolina Digestive Endoscopy Center

ALTERNATIVE CONFIDENTIAL COMMUNICATIONS AND ACKNOWLEDGEMENT OF THE NOTICE OF PRIVACY PRACTICES

Patient Name _____ Date of Birth _____

If we are unable to reach you, we will need an alternative method of communicating information to you. Check the box next to the method(s) you would like Carolina Digestive Endoscopy Center to use to communicate personal health, treatment, or payment information to you. This is the most current request that supercedes all prior requests. You may update this request as needed.

- ☐ E-mail: I recognize that email may not be secure, but I authorize you to email me anyway.

(E-mail address at which I wish to be contacted)

- ☐ I authorize you to leave detailed information at the following number

Phone _____

- ☐ Alternative Contact: _____
(name of person CDHA may contact when unable to reach me)

I understand that this contact person is permitted to receive detailed health information, such as test results.

Phone: _____

Address: _____

By signing below I authorize Carolina Digestive Endoscopy Center to communicate protected health information to me as described above. I further acknowledge that I have been given the opportunity to read the Notice of Privacy Practices for Carolina Digestive Endoscopy Center describing how my protected health information may be used and disclosed as permitted under federal and state law. I understand that I may obtain a complete copy of the Notice for my records upon request at any time.

Signature

Date

Office Use Only

We were unable to obtain a written acknowledgement of the Notice of Privacy Practices because:

- ☐ An emergency existed and a signature was not possible at the time.
- ☐ The individual refused to sign.
- ☐ Unable to communicate with the patient for the following reason:

• _____

- ☐ Other:

CDEC Employee _____ Date _____