

**Surgical Specialists of Greenwich, P.C.**

77 Lafayette Place, Suite 301 – Greenwich, CT 06830

Tel (203) 863-4300 – Fax (203) 863-4310

Please Print

Name of Patient: \_\_\_\_\_ D.O.B. \_\_\_\_\_

**I hereby authorize you to contact me to confirm appointments, to communicate information related to my personal health and treatment, and for purposes of obtaining payment.**

Please select all that apply and number your preference (i.e. 1<sup>st</sup>, 2<sup>nd</sup>, 3<sup>rd</sup>)

\_\_\_\_ Phone me at Home: \_\_\_\_\_  
Work: \_\_\_\_\_  
Cell: \_\_\_\_\_  
Other: \_\_\_\_\_

\_\_\_\_ **Do** \_\_\_\_ **Do NOT**  
**Leave Messages on my Answering Machine or with Any Other Person**  
*\*Messages are generally to confirm appointment times. No medical information will be left.*

\_\_\_\_ **Mail** me at: \_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_ **E-mail** me at: \_\_\_\_\_

\_\_\_\_ **Fax** me at: \_\_\_\_\_

**I hereby give Surgical Specialists of Greenwich, P.C. permission to speak to a family member/significant other regarding my personal health and treatment, and for purposes of obtaining payment.**

**I have received or hereby acknowledge that I am entitled to receive a copy of the medical practice's *Notice of Privacy Practices*. I further acknowledge that a copy of the current *Notice of Privacy Practices* was posted in the reception area and am aware that I may request a copy of any amended *Notice of Privacy Practices* at each appointment or in writing.**

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name if Other Than Patient: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

**FOR OFFICE USE ONLY:**

\_\_\_\_ *Signed form Received By:* \_\_\_\_\_ *Date:* \_\_\_\_\_

\_\_\_\_ *Acknowledgement Refused because:* \_\_\_\_\_