COLON AND RECTAL SURGERY INC. AND THE COLONOSCOPY CENTER INC.

ELECTION AND CONSENT FOR PHYSICIAN COMMUNICATIONS

*****OPTIONAL*****

I understand CRS/CCI does not and cannot guarantee the confidentiality of any voicemail messages or email communications and will not be liable for improper disclosure of confidential information and/or breaches in information caused by me or a third party.

I hereby voluntarily request and consent to communicate with my physician and/or office personnel via the following communication methods.

1. Primary Number: _____ ___Home ___Work ___Mobile ___ Other ___ Doctor name and appointment information ___ Test results ___ Appointment instructions ___ Billing information	2. Secondary Number: _____ ___Home ___Work ___Mobile ___ Other ___ Doctor name and appointment information ___ Test results ___ Appointment instructions ___ Billing information
3. Tertiary Number: _____ ___Home ___Work ___Mobile ___ Other ___ Doctor name and appointment information ___ Test results ___ Appointment instructions ___ Billing information	4. Primary Email Address: _____ ___Home ___Work ___ Other ___ Appointment instructions

This is to authorize and request that you provide a copy of the results of my procedure(s) to the following:

1. _____

☐ Primary care doctor
☐ Other

2. _____

☐ Primary care doctor
☐ Other

_____ _____ _____

Patient Signature | Patient Printed Name | Date

If Patient is a Minor, has a Legal Guardian or a Power of Attorney exists:

_____ _____ _____

Responsible Party Signature | Responsible Party Printed Name | Date