Wake Forest Endoscopy Center

10540 Ligon Mill Rd., Suite 109
Wake Forest, NC 27587

Effective April 14, 2003, a new federal regulation, known as "HIPAA Privacy Rule," requires that we provide detailed notice in writing of our privacy practices. Attached is a SUMMARY OF NOTICES OF PRIVACY PRACTICES for Wake Forest Endoscopy Center. An authorization instructing our office on how to communicate with you about any healthcare information pertaining to your treatment and billing information is also included. **Please read, complete, and sign all attached authorization according to your preference(s).**

If your appointment is scheduled at Wake Forest Endoscopy Center, please bring all completed HIPAA authorization forms along with your completed registration forms and insurance cards to your appointment. PLEASE DO NOT MAIL REGISTRATION FORMS TO OUR OFFICE.

If your procedure is scheduled at the hospital, only mail the completed/signed HIPAA authorization forms back to our office to the address listed below:

Wake Forest Endoscopy Center
10540 Ligon Mill Rd.
Suite 109
Wake Forest, NC 27587

If your procedure is scheduled at the hospital, please complete the enclosed medical forms for the facility where your procedure is scheduled and take with you on the day of your procedure. Do not mail the hospital forms back to Wake Forest Endoscopy Center, as the hospital will need this paperwork.

If you have any questions please call (919) 439-3393.

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Chart # _____ Date _____

I give my permission for the providers of the Wake Forest Endoscopy Center to release ANY information about my medical condition, prescriptions, and financial account to:

Name: _____
Name: _____
Name: _____

Below, I give my, permission for the providers of the Wake Forest Endoscopy Center to release prescriptions and samples ONLY to:

Name: _____
Name: _____
Name: _____

The above mentioned person (s) will be required to provide photo ID when picking up requested items.

Patient name: _____ DOB: _____

Patient signature: _____

By signing on the line below, I acknowledge that 1 was provided access to Privacy Practices of the Wake Forest Endoscopy Center:

Print Name: _____ DOB: _____

Patient Signature: _____

For Personal Representation of the patient (if applicable)
Print Name of Personal Representative: _____
Representative's Relationship (i.e. parent/guardian/other, etc.): _____
Signature of Personal Representative: _____

_____ I refuse to acknowledge I was provided access to the Notice of Privacy Practices of Wake Forest Endoscopy Center:

_____ _____
Signature of Practice Employee Date