ABDOMINAL SPECIALISTS OF SOUTH TEXAS, LLP
718 Elizabeth St., 3rd Floor, Corpus Christi, Texas 78404, Ph: 361-884-2858 Fax: 361-879-9009

NOTICE OF PRIVACY PRACTICES

By signing below, you acknowledge that you have received this Notice of Privacy Practices prior to any service being provided to you by Abdominal Specialists of South Texas, and you consent to the use and disclosure of your Personal Health Information to carry out treatment, payment activities and healthcare operations as set forth herein excepts as expressly stated below. (Available upon request)

Patient Name: _____ **Date of Birth**: _____

- I hereby request the following **restrictions** on the use and/or disclosure (specifically as applicable) of my information:

_____

- Personal Protected Information **may be released to** the following family members/friends: (Please provide full name & relationship)

_____

_____

- Who **is allowed** to pick up prescriptions or medication samples on your behalf?

_____

_____

Signatures:

Patient or Legal Representative: _____ **Date:** _____

If Legal Representative, what is your relationship to patient? _____

Witness (optional): _____ Date: _____