65th Street GI Office-Based Surgery - 201 East 65th Street - New York, NY 10021 - 212-879-4700

GENERAL INFORMATION AND E-MAIL AUTHORIZATION PAGE

Date		Last and First Name			ID#		DOB		Age	0	○ M	○ F

I understand that I have been scheduled for a

The procedure will be performed by in the Endoscopy Suite owned by Dr. Robert Segal. I have been informed that is a licensed physician in New York State, Board Certified in Internal Medicine and Gastro-Enterology. I have also been informed that anesthesia will be administered by , a licensed physician in New York State, Board Certified in Anesthesiology and

I have been provided with copy of the Privacy Policies of the practice, as required by the HIPAA regulations. I have also received a copy of the Patient Bill of Rights. I have been informed that I may receive a copy of the 3-steps Grievance Procedure that I may follow if I am not satisfied with the care received.

I have been advised that the physicians and other staff members of this practice will not honor any DNR (Do Not Resuscitate) order and I understand that full resuscitation will be attempted in any case of cardiac arrest.

I have been given the option to receive a copy of my consent form and have ○ Requested ◉ Not Requested it.

I authorize release of the medical forms related to this procedure to the E-Mail address

☐ Send Forms by E-Mail