Gastroenterology Associates, **PLLC**

Gastroenterology and Hepatology

RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of the Notice of Privacy Practices, pages 1-5, which fully describes the uses and disclosures that can be made of my individually identifiable health information for treatment, payment and health care operations. If I refuse to sign receipt of this Notice, Gastroenterology Associates can refuse to treat me.

PERSONAL MESSAGES REGARDING MY HEALTH AND TEST RESULTS MAY BE LEFT ON MY VOICE MAIL OR ANSWERING MACHINE.

☐ **YES Date ____________ Initials _________ Phone # to leave message _______________**

☐ **NO, except to return a call or appointment reminder.**

____ ____________________

Signature of patient or patient's representative Date

____ ____________________

Printed name of patient or patient's representative Patient's Date of Birth

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Relationship to the patient

I give my permission for the following individuals (include family members and friends) to receive personal health information about me. This permission will be binding until revoked in writing by me.

1. ______________________________________ relationship to me __________________.
2. ______________________________________ relationship to me __________________.
3. ______________________________________ relationship to me __________________.
4. ______________________________________ relationship to me __________________.