ASSOCIATED GASTROENTEROLOGY CONSULTANTS, INC.

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Patient #

PRIVACY PRACTICES ACKNOWLEDGEMENT FORM

I, _____, hereby acknowledge receipt of the practice's Notice of
(Print Patient's Name)
Privacy Practices. The Notice of Privacy Practices provides detailed information about how the practice may use and disclose my confidential information.

May we leave a message on your answering machine at home or on your cell phone? YES NO

In addition to the *Statement of Uses and Disclosures* set forth in the Notice, the practice may disclose my health information (test results, diagnosis, treatment plan, etc…) to the following family members and treating physicians:

Name _____Relationship_____Phone_____DOB_____

Name _____Relationship_____Phone_____DOB_____

Name _____Relationship_____Phone_____DOB_____

Name _____Relationship_____Phone_____DOB_____

I understand that the practice will request that I update this form periodically. I also understand that I have the right, at any time, to amend the information I provide by notifying the practice in writing and/or by completing a new Privacy Practices Acknowledgement Form.

I understand that the practice has reserved a right to change its privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided to me or made available.

Signed: _____ Date: _____

If you are not the patient, please specify your relationship to the patient _____