ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

- I have received a copy of this office's Notice of Privacy Practices.

- You may disclose my health information to the following people: [please state name and relationship; you may also list their phone number(s) if you would like us to contact them in the event we are unable to reach you]:

  _____

  _____

  _____

  _____

  _____

*****Please note that no information will be given to anyone not listed above*****

- Please identify the means by which you prefer we contact you (**check all that apply**):
  - ☐ Home Phone
  - ☐ Answering machine message
  - ☐ Work phone
  - ☐ Voice mail message
  - ☐ Cell Phone
  - ☐ Other (please specify): _____

- Is there anyone other than yourself you would like for us to speak with regarding insurance and billing matters?
  Yes No (Please circle)

  If yes, please state name, relationship and phone number they can be reached:

  Name: _____ Phone: _____

- _____ _____
  Patient Signature Patient Printed Name
  If patient is a minor or unable to sign:

  _____ _____
  Patient Representative Relationship to Patient

  _____
  Date

For office use only:
In lieu of patient signature, I, _____, an employee of Gastroenterology Clinic of Acadiana, state that the above named patient has been given our current Notice of Privacy Practices.

_____ _____
Employee Signature Date