Acknowledgment of Receipt of GASTROENTEROLOGY ASSOCIATES OF SUFFOLK, P.C.
Notice of Patient Privacy

By my signature below, I hereby acknowledge receipt of this Notice of Privacy Practices, and I acknowledge that the Practice will use and disclose my health information for purposes of treating me, obtaining payment for services rendered to me, and conducting health care operations.

I have been advised of my rights to obtain access to and control my Protected Health Information. I also understand that in providing treatment, submitting billing and conducting healthcare operations GASTROENTEROLOGY ASSOCIATES OF SUFFOLK, P.C. may need to disclose my protected health information to members of my family or certain close personal friends. By providing the requested information below, I further authorize the disclosure of my protected health information as follows:

Please check the appropriate boxes (if applicable)

☐ If I am unavailable, I expressly permit GASTROENTEROLOGY ASSOCIATES OF SUFFOLK, P.C. to disclose my protected health information—for the purposes of appointment/test/procedure reminders and follow-up—to the following individuals:

_____ _____ (relationship to me)

_____ _____ (relationship to me)

_____ _____ (relationship to me)

_____ _____ (relationship to me)

_____ _____ (relationship to me)

☐ I expressly permit GASTROENTEROLOGY ASSOCIATES OF SUFFOLK, P.C. to disclose my protected health information—for the purposes of appointment/test/procedure reminders and follow-up—by leaving such information in the form of a message on the following recorded media:

Home answering machine: Tel # _____

Office voice mail: Tel # _____

Other (specify): Tel # _____

_____

_____ Date: _____

Signature of Patient or of
Personal Representative, or
parent/guardian