Digestive Health *Specialists*

Acknowledgment and Receipt of Notice of Privacy Practices

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this acknowledgment. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy by submitting a request.

By signing this form, you acknowledge receipt of our notice regarding use and disclosure of protected health information about you for treatment, payment and health care operations as described in the notice.

Please specify which one of these phone numbers we may leave a message on:

☐ **Mobile** ☐ **Home** ☐ **Work** ☐ **None**

RELEASE OF INFORMATION:

Please list anyone whom you want to have verbal and/or physical access to your health care information. This information will be retained in your medical record unless you direct Digestive Health Specialists in writing to revoke or change.

Name: **Relationship:** **Phone Number:**

____

____

____

____

EMERGENCY CONTACT:

Please list your emergency contact below. This person may not receive verbal and/or physical access to your healthcare information unless listed above. This information will be retained in your medical record unless you direct DHS in writing to revoke or change.

Name: **Relationship:** **Phone Number:**

____

Print Patient Name: ______________________________DOB: ________________

Patient/Representative Signature: ______________________________________

Date: _______________________

For Office Use Only:

I have attempted to obtain the patient's signature on this form, but was not able to obtain it for the reason listed below:

Staff member initials: ________ Date: ___________________

Reason:

Revised 09/09/14