PRIVACY NOTICE ACKNOWLEDGMENT

Patient Name: _____
Name of Patient's Parent(s) or Legal Guardian: _____
Date of Service: _____

Acknowledgement of receipt of Privacy Practices Notice

I, _____, acknowledge that I have either received, or been offered, a Privacy Practices Notice from Pediatric Gastroenterology Associates, PC.

Further, by signing below I provide my permission for Pediatric Gastroenterology Associates to use and disclose my medical information for the permitted purposes of treatment, payment, and health care operations as discussed in the Notice of Privacy Practices.

Patient (or Guardian/legal Guardian) Signature: _____ Date: _____

If a personal representative on behalf of the patient signs this authorization, complete the following:

Name of Patients Personal Representative: _____
Relationship to Patient:_____

IF NOT SIGNED: (Good Faith Effort to obtain acknowledgement of receipt)

Describe the good faith effort of the physician practice to obtain the signature of the patient (or the patient's parent(s)/legal guardian) on this form:

_____

_____

_____

Describe the reason(s) why the individual would not sign this form:

_____

_____