



PRIVACY NOTICE ACKNOWLEDGMENT

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This form is used to document

- a) An individual's acknowledgement of receipt of the Privacy Notice of Pediatric Gastroenterology Associates, or
  - b) When an acknowledgment is not received, this form is used to document the good faith effort of Pediatric Gastroenterology Associates to obtain the acknowledgement.
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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:

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

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