THE CENTER FOR
Digestive & Liver Health
and The Endoscopy Center

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Patient Name _____ Date of Birth _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, hereby acknowledge that The Center for Digestive & Liver Health and The Endoscopy Center (CDLH), divisions of AGA, LLC and its affiliates (AGA), have given me the opportunity to read a detailed notice of their Privacy Practices.

CONSENT TO COMMUNICATE WITH YOU

D I authorize CDLH/AGA to leave results or protected health information on my voicemail. o Home o Cell o Work

While CDLH/AGA takes reasonable precautions to protect your confidential information, email is not a completely secure method of communication.

D I authorize my CDLH/AGA physician and/or his/her representative to correspond with me via email regarding medical care if I initiate the email contact. The email address being authorized is: _____

CONSENT TO COMMUNICATE WITH OTHERS

D I **do not** authorize CDLH/AGA to communicate with anyone other than me, excluding all disclosures allowed by law.

D I authorize representatives from CDLH/AGA to share information regarding care or tests results with the individuals listed below if I cannot be reached. These individuals may also request protected health information on my behalf.

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

I recognize that CDLH/AGA may share my protected health information with other healthcare providers, including sensitive health information such as: HIV/AIDS information, substance abuse records, genetic testing information, and developmental disability records. This information may be shared with other healthcare providers via various methods, including but not limited to, fax or health information exchange.

_____ Date _____

Patient/Authorized Representative Signature **If patient is a minor (under the age of 18), form must be signed by a parent or legal guardian.*

FOR OFFICE USE ONLY

If patient does not sign this form, please provide a reason why the acknowledgement was not obtained and witness.

_____

Reason(s)

_____ Date _____

Witness / Staff Signature