PACIFIC GASTROENTEROLOGY MEDICAL ASSOCIATES, INC.

PRIVACY PRACTICES NOTICE AND ACKNOWLEDGEMENT

Last Name _____ First Name _____ Date of Birth _____

Privacy Notice: This notice describes how your medical information may be used and disclosed for the purposes of treatment, payment, and healthcare operations, and how you can access this information. This explains your rights and our obligations under the law. This notice may be revised from time to time.

We have available a detailed Notice of Privacy Practices which fully explains your rights and our obligations under the law. This is also available online at www.PacificGastro.com .

Acknowledgement: I acknowledge that I have been provided an opportunity to review and receive the notice of privacy practices.

RELEASE OF INFORMATION

☐ I authorize the release of my protected health information (PHI) to the following individual(s):

- ☐ Spouse: Name _____
- ☐ Child(ren): Name(s) _____
- ☐ Other: Name and relationship _____

This ***Release of Information*** will remain in effect until terminated by me in writing.

MESSAGES

Please call: ☐ First preference Phone # _____

☐ Second preference Phone # _____

If unable to reach me:

- ☐ You may leave a detailed message
- ☐ Please leave a message asking me to return your call
- ☐ _____

The best time to reach me is (*day*)_____ between (*time*)_____

Signature of Patient/Guardian _____ Date _____