Gastrointestinal Surgical Specialists, LLC

Acknowledgement of Receipt Of Notice of Privacy Practices

Patient Name & Address

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I have received a copy of the Notice of Privacy Practices for the above-named practice.

______________________________ ______________

Signature Date

In addition to releasing my information to other healthcare providers and/or insurance companies, I authorize you to share my medical information with the following people:

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FOR OFFICE USE ONLY

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- 0 An emergency existed & a signature was not possible at the time.
- 0 The individual refused to sign.
- 0 A copy was mailed with a request for a signature by return mail.
- 0 Unable to communicate with the patient for the following reason:
  ____
- 0 Other: ____
  ____
  ____

Prepared By ______________________________

Signature ______________________________

Date ______________________________