Gastroenterology Specialties P.C. Lincoln Endoscopy Center, L.L.C.

ACKNOWLEDGEMENT OF RECEIPT OF THE NOTICE OF PRIVACY POLICIES

I have received the NOTICE OF PRIVACY POLICIES OF GASTROENTEROLOGY SPECIALTIES, PC AND LINCOLN ENDOSCOPY CENTER, LLC

I understand that:

1. A copy of this signed Acknowledgement of Receipt of Privacy Policies will be kept on file.
2. If I am unable or choose not to sign this document, a staff member will sign their name and date, to verify the Notice of Privacy Policies was given to me.
3. If I desire a copy of the Notice of Privacy Policies, or my signed copy of the Acknowledgement of Receipt of The Notice of Privacy Policies, I may be given such copy upon request.

Name_____

Address_____

City_____ State_____ Zip_____

_____ _____ or _____ _____

SIGNATURE OF PATIENT **DATE** **PARENT/LEGAL GUARDIAN/AUTHORIZED PERSON** **DATE**

Authorization to disclose personal health information to:

(please list self only, family members, or other persons)

_____

_____

_____

_____ _____or _____ _____

SIGNATURE OF PATIENT **DATE** **PARENT/LEGAL GUARDIAN/AUTHORIZED PERSON** **DATE**

Staff member signature if patient is unable to or refuses to sign the Acknowledgement of receiving the Notice of Privacy Policies.

_____ _____

STAFF MEMBER SIGNATURE DATE