ACKNOWLEDGEMENT OF RECEIPT OF THE NOTICE OF PRIVACY POLICIES

GASTROENTEROLOGY SPECIALTIES, PC AND LINCOLN ENDOSCOPY CENTER, LLC
4545 R STREET, SUITE 100 LINCOLN, NE 68503   402-465-4545

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 were 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 verbal or written personal health information to:
____

Authorization to send billing information to:
____

______________________ ________ 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