Associates *in* Digestive Diseases
— Gastroenterology and Hepatology —

Acknowledgement of Privacy Practices Notice and Designation of Disclosure Form

I. Acknowledgement of Privacy Practice Notice

I have been offered a copy of Associates in Digestive Diseases' Notice of Privacy Practices.

_____ _____
Print Patient Name Date of Birth

_____ _____
Signature of Patient or Guardian Date

II. I wish to be contacted in the following manner (check all that apply)

☐ DO NOT SPEAK TO ANYONE BUT MYSELF

	Home	Cell
☐ OK to leave a brief message on your answering machine	☐ yes ☐ no	☐ yes ☐ no
☐ OK to leave TEST RESULTS on your answering machine	☐ yes ☐ no	☐ yes ☐ no

☐ OK to leave a message with detailed information with a family member
☐ OK to leave message with a call back number only on machine/voicemail
☐ OK to mail results to my home address

III. Designation of Certain Relatives, Close Friends, and Other Caregivers

I agree that Associates in Digestive Diseases, PA may disclose certain of my health information to a family member, close personal friend, or other caregiver because such person is involved with my health care or payment relating to my healthcare. In that case, Associates in Digestive Diseases, PA will disclose any information that is directly related to the person's involvement with my health care or payments relating to my health care.

I designate the following person(s) listed below as person(s) involved with my health care or payment relating to my health care for the purposes of Associates in Digestive Diseases, PA making the limited disclosures described above. I understand that I am not required to list anyone and that I may change this designation at any time in writing.

Print Name: _____ Date of Birth: _____ Phone Number: _____

Print Name: _____ Date of Birth: _____ Phone Number: _____

Print Name: _____ Date of Birth: _____ Phone Number: _____

_____ _____
Signature or Patient or Guardian Date