Last Name: First Name: **PRINT**

DOB:

SOUTHWEST GASTROENTEROLOGY & OAK LAWN ENDOSCOPY

RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge receipt of the Notice of Privacy Practices. The Notice of Privacy Practices provides detailed information about how my confidential information may be used and disclosed.

I understand that Southwest Gastroenterology and Oak Lawn Endoscopy have reserved a right to change their privacy practices that are described in the Notice. I also understand that a copy of any revised notice will be provided to me or **made available on my next office visit or upon my request.**

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so, to the physician. I also understand that I will not be able to revoke this consent in cases where the physician has already relied on it to use or disclose my health information. Written revocation of consent must be sent to the physician's office.

Signature: _____ Date: _____

OTHER USES OR DISCLOSURES WE CAN MAKE WITH YOUR WRITTEN AUTHORIZATION

Please list below the people you give us permission to disclose your protected health information to:

Name: _____ Relationship: _____ Name: _____ Relationship: _____

Name: _____ Relationship: _____ Name: _____ Relationship: _____

As stated in our Notice of Privacy Practices, you have the right to request that you receive communication in a certain manner or at a certain location. You also have the opportunity to object to certain disclosures. Please list any special instructions below:

_____

_____

Signature: _____Date: _____

FOR PRACTICE USE ONLY – REFUSAL TO SIGN

REASON FOR REFUSAL: _____

WITNESS: _____ DATE: _____