Acknowledgement of Receipt of Notice of Privacy Practices

Julie Morris – Privacy Officer
(860) 347-4620

Name of Patient: ____

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I may request a copy of any amended Notice of Privacy Practices at each appointment.

Signed: ____________________________ Date: _________________

Print Name: ________________________ Telephone: _____________

If not signed by the patient, please indicate your relationship to the patient:

____

I authorize Middlesex Gastroenterology Associates to release personal health information to the name(s) listed below:

Name(s): ____

Relationship to patient: ____

(Please check appropriate lines)

_____ Call my home/cell phone and if necessary leave a message on the answering machine/voice mail/with a family member for me to call you back to schedule an appointment or to return your call.

_____ Call my home/cell phone and if necessary leave a message on the answering machine/voice mail/with a family member giving the results of any test.

Signature: _________________________________ Date: ______________