Patient Name:_____ DOB:____/____/_____

G.I. Medicine Associates, PC

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

The undersigned Patient or legally authorized representative of the Patient acknowledges that he or she personally was offered the opportunity to review a copy of the **G.I. Medicine Associates, PC Notice of Privacy Practices** on the date indicated below.

Signature: _____ Date: _____

Designation of Personal Representative

As required by the Health Information Portability and Accountability Act you have the right to nominate one or more persons to act on your behalf with respect to the protection of health information that pertains to you. By completing this form you are informing us of your wish to designate the named person as your personal representative. You may revoke this designation at any time by completing the revocation form.

I,_____(Patient's Name), hereby nominate the following person to act as my personal representative with respect to decisions involving the use and/or disclosure of health information that pertains to me.

Print Name of Personal Representative:_____

Please fill out the information listed below. This section is for security purposes. When your personal representative calls for your information this will enable our staff confirm the personal representative's identity.

Personal Representative Telephone#_____

The authority of this person when acting as my personal representative is restricted to the following functions: (Please Describe):

(Note: In lieu of description of the privileges to be afforded the personal representative alternative text may say: "This procedure is to be afforded all of the privileges that would afford to me with respect to my health information").

☐ Patient Declined Personal Representative

_____ _____

Patient's Signature Date