

# Digestive Health Specialists

## Acknowledgment and Receipt of Notice of Privacy Practices

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this acknowledgment. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy by submitting a request.

By signing this form, you acknowledge receipt of our notice regarding use and disclosure of protected health information about you for treatment, payment and health care operations as described in the notice.

Yes  No I authorize Digestive Health Specialists to call my primary phone number and leave a message.

Yes  No I authorize Digestive Health Specialists to call my secondary phone number and leave a message.

Please list anyone whom you want to have verbal and/or physical access to your health care information. This information will remain in place until you direct DHS otherwise.

**Name:**

**Relationship:**

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Patient Name \_\_\_\_\_

Patient/Representative Signature \_\_\_\_\_

Date \_\_\_\_\_