NASHVILLE GASTROINTESTINAL SPECIALISTS, INC.

Notice of Privacy Practice Acknowledgement Form

By my signature below, I am acknowledging I have received a copy of Nashville Gastrointestinal Specialists, Inc.'s **Notice of Privacy Practice** concerning my protected healthcare information.

_____ _____
Patient Name(Printed) Date

_____
Patient or Patients's Representative Signature

I authorize the following individuals to receive information about my health status, which may include information about my protected healthcare information.

_____ _____
Print Name Relationship, Date of Birth

_____ _____
Print Name Relationship, Date of Birth

_____ _____
Print Name Relationship, Date of Birth

I authorize Nashville Gastrointestinal Specialists, Inc. to leave health information on my answering machine: Yes ❑ No ❑ or on my cell phone voice mail: Yes ❑ No ❑

I understand Nashville Gastrointestinal Specialists, Inc. will only release my protected healthcare information to the individuals that I have indicated on this form. All other requests for protected healthcare information must be made in accordance with the Nashville Gastrointestinal Specialists, Inc. HIPAA Policy and Procedure Manual concerning the privacy of my protected healthcare information.

_____ _____
Patients Name (Printed) Date

_____
Patient or Patient's Representative Signature

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