

# Marin Gastroenterology

## Patient Acknowledgement of Privacy Practices

As the laws regarding patient privacy are changing and new procedures are being put into effect, it is our responsibility to notify you as well as receive feedback from you about how your records will be handled. This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

**\*PLEASE INITIAL that you have read and understand each statement. If you wish to make changes to a section, please notify the receptionist so that your file is noted properly in our records. Please sign and date the bottom.**

\_\_\_\_\_ I am aware that the Notice of Privacy Practices is available for me to read here in the office, and I may receive a copy upon request.

\_\_\_\_\_ I am aware the staff will identify themselves as a doctor's office when confirming appointments, returning my calls or for routine follow-up calls. I further understand any message left for me will not include test results or other identifiable medical information.

\_\_\_\_\_ I am aware my gastroenterologist makes it a practice to keep my primary care and/or specialty physicians notified of my progress by sending a report detailing my initial visit and subsequent visits as needed.

\_\_\_\_\_ I authorize the staff of this office to release pertinent information to any physician or provider they refer me to for future care.

\_\_\_\_\_ **I authorize the following person(s)**(Example: spouse, family, friend, bookkeeper)

(PLEASE PRINT) \_\_\_\_\_

\_\_\_\_\_ **to have access to my medical information, including receiving test results, taking advice regarding my condition, making my appointments and discussing my billing issues. I may change this at any time by signing a new form.**

\_\_\_\_\_ I understand that the above information is in effect immediately and shall remain in effect unless a new Patient Acknowledgement of Privacy Practices form is signed and dated with changes made by me.

Please note in order to avoid misuse of your protected medical records or information, it is our policy to release minimum amount necessary, even to those you have agreed may have access.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_  
(PLEASE PRINT)