WASHINGTON GASTROENTEROLOGY

Notice of Privacy Practices Acknowledgement

Washington Gastroenterology and its affiliated healthcare partners who constitute a clinically integrated organized healthcare arrangement: Western Washington Endoscopy Center, Eastside Endoscopy Center, Gastroenterology Associates Endoscopy Center, Narrows Anesthesia Services and Paceline Anesthesia, has a responsibility to protect the privacy of your health care information and to provide a Notice of Privacy Practices that describe how your healthcare information may be used and disclosed, how you can access your health information, and whom to contact if you have questions, concerns, or complaints. You have the right to review our Notice of Privacy Practices before signing this acknowledgement.

We may change the Notice of Privacy Practices at any time. You may contact our office to obtain a current copy of the Notice of Privacy Practices or to ask questions.

By signing this form, I acknowledge receipt of the Notice of Privacy Practices, or that I have been given the option to receive a copy of the Notice of Privacy Practices.

I authorize Washington Gastroenterology to disclose personal health care information and/or review my care with the following family members, friends or individuals involved in my care. This permission will be binding until revoked in writing by me.

Name _____ Relationship to me _____ Phone _____

Name _____ Relationship to me _____ Phone _____

Name _____ Relationship to me _____ Phone _____

Name _____ Relationship to me _____ Phone _____

Emergency contact(s) if not listed above:

Name _____ Relationship to me _____ Phone _____

Name _____ Relationship to me _____ Phone _____

I authorize Washington Gastroenterology to leave detailed personal messages for the purpose of appointment confirmation, test results, and/or to communicate with me about my health care information.

- ❑ Home _____
- ❑ Cell _____
- ❑ Work _____
- ❑ I do not authorize detailed messages to be left on any phone numbers listed for me.

_____ _____

Printed Name of Patient | Date of Birth

_____ _____

Signature of Patient or Patient's Representative | Date

_____ _____

Printed Name of Patient's Representative (if signing above) | Relationship to Patient

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For Office Use Only

I have attempted to obtain the patient's signature on this form, but was not able to obtain it for the reason(s) listed below.

Reason(s) _____

Staff member initials _____ Date _____