



**ADVANCED
DIGESTIVE
CARE**

ASSOCIATES IN GASTROENTEROLOGY

**Associates in Gastroenterology
&
Endoscopy Associates, LLC**

Notice of Privacy Practices Acknowledgement Form

This is a summary of our Notice of Privacy Practices. The entire text detailing our privacy practices is available for your review, and we encourage you to read it and ask any questions you may have regarding our privacy practices. If you have any questions or would like to exercise any of your rights, please contact our Privacy Officer. After reviewing the material, please sign in the space provided below.

PATIENT RIGHTS YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

You have the following rights regarding your PHI. You may:

1. Inspect and copy health data by submitting a written request to our Privacy Officer
2. Amend protected health information, if you believe it is incorrect, by submitting a written request to our Privacy Officer
3. Receive a list of disclosures made of your protected health data. To obtain this list of disclosures, you must submit your request in writing to our Privacy Officer. We may charge you for the costs of providing this list. We will notify you of the cost involved and you may choose to withdraw or modify your request at any time before any costs are incurred
4. Request restrictions on certain uses and disclosures of facts about you. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for it, such as a family member or friend. For example, you could ask that we not use or disclose information about a surgery you may have had. However, we are not required to agree to the requested restrictions. To request restrictions, you must submit a written request to our Privacy Officer
5. Receive confidential communication of protected health data by giving us a specific means of communication. For example, you can request that we only contact you at work or via U.S. mail. Please submit such a request in writing to our Privacy Officer
6. Obtain a paper copy of this notice upon request, if you agreed to originally accept this notice via e-mail or facsimile
7. You have the right to receive notice of breach of unsecured PHI. Unauthorized acquisition, access, use or disclosure of unsecured PHI is presumed to be a breach unless it is demonstrated that there is a low probability that there is a low probability that the PHI has been compromised.
8. You have the right to restrict disclosure of psychotherapy notes and PHI if treatment is paid for out of pocket. You may request that PHI not be disclosed to a health plan if the item is typically disclosed for payment or health care operations (and not otherwise required by law) and the item/service has been paid in full by the individual or someone other than the health plan.

PROVIDER RIGHTS

As your health care provider, we can use or disclose your PHI for treatment, payment, or health care operational purposes. Any other disclosure requires you to sign a specific authorization.

Patient Name

Date of Birth

Patient Signature

Date



For Staff Use Only:

Written acknowledgement was not obtained for the following reasons:

Staff Name

Staff Signature

Date