



Site information/Label Site: _____ Address: _____ _____
--

Notice of Privacy Practices Acknowledgement

Patient Name: _____ Date of Birth: _____

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (“HIPAA”), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used for treatment, payment and healthcare operations.

By signing this form, I acknowledge that I have viewed and have been offered a copy of U.S. Digestive Health’s “Notice of Privacy Practices” (“NPP”). This NPP describes in detail how we might use or disclose your protected health information.

I understand that this organization has the right to change its NPP from time to time and I may request a copy of the NPP at any time or review it on the company website.

I am aware that I may request a copy of the NPP at any time and that a current version of the NPP is available at www.USDigestiveHealth.com under “Privacy Policy”.

Signature of Patient or Authorized Representative

Date

Relationship to Patient

If Applicable

The patient refused or was unable to acknowledge the Notice of Privacy Practices (please indicate reason:

Staff Representative Signature

Date