West Gastroenterology Medical Group

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE H2.6C

I, ______________________________, HEREBY ACKOWLEDGE RECEIPT OF THE NOTICE OF PRIVACY PRACTICES GIVEN TO ME BY WEST GASTROENTEROLOGY MEDICAL GROUP.

MY PROTECTED HEALTH INFORMATION MAY BE DISCLOSED TO THE FOLLOWING INDIVIDUAL(S):

	NAME OF INDIVIDUAL	RELATIONSHIP TO PATIENT
1.	______________________	______________________
2.	______________________	______________________
3.	______________________	______________________

PATIENT SIGNATURE: ______________________________ DATE: ______________

FOR OFFICE USE ONLY

IF NOT SIGNED, REASON WHY ACKNOWLEDGEMENT WAS NOT OBTAINED:

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PERSON SEEKING ACKNOWLEDGEMENT: ______________________ DATE: __________