Patient Name: ______________________________

Date: ______________________________

Office Use Only

Patient Name:______________________

ID#:_____ **Physician #:**_____ **Date:**

Permission to Disclose Information to Those Involved in My Care

I hereby allow **Kansas Gastroenterology, LLC,** to disclose the following Protected Health Information to the below listed People, in the following Forms of communication:

(PLEASE CHECK ALL BOXES THAT APPLY)

Protected Health Information (What information can we give out?)	People (Name and phone number) (Who can we give information to?)
☐ All	☐ Self Only
☐ Appointment times and dates	**OR**
☐ Tests that have been received	(Please provide first and last names)
☐ Test results	☐ Spouse ______________
☐ Other health information	☐ Family friend ______________
	☐ Child ______________
	☐ Other ______________

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGMENT FORM

I, ________________________, have received a copy of **Kansas Gastroenterology, LLC** "Notice of Privacy Practices".

X______________________________ ____________________

Signature of Patient Date

(For Office Use Only)

Documentation of Good Faith Efforts

The patient presented to **Kansas Gastroenterology, LLC** on ______________ and was provided with a copy of this office's Notice of Privacy Practices. A good faith effort was made to obtain from the patient a written acknowledgment of his/her receipt of the Notice. However, such acknowledgment was not obtained because:

☐ Patient refused to sign.

☐ Patient was unable to sign or initial because:

____

☐ The patient had a medical emergency, and an attempt to obtain the acknowledgment will be made at the next available opportunity.

☐ Other reason (describe below):

____

Signature of Employee Completing Form: ____________________________

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