

For office use only

Patient Name: _____

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?)

- All
- Appointment times and dates
- Tests that have been received
- Test results
- Other health information

People (Name and phone number)
(Who can we give information to?)

- Self Only
- OR**
- (Please provide first and last names)
- Spouse _____
 - Family friend _____
 - Child _____
 - Other _____

Forms of Communication
(How may we contact you?)

- Home telephone _____
- Work telephone _____
- Home voice messaging system _____
- Work voice messaging system _____
- Cellular phone _____
- E-mail _____
- U.S. Mail _____
- 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

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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: _____