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?)

- ☐ 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 with phone number)

- ☐ Spouse Name/Phone Number:_____
- ☐ Family friend Name/Phone Number:_____
- ☐ Child Name/Phone Number:_____
- ☐ Other Name/Phone Number:_____

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: _____

3121 N. Webb Rd
Wichita, KS 67226

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f 316-261-3275