SWGA SWE
Southwest Gastroenterology Associates P.C.
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Acknowledgment of Receipt of Notice of Privacy Practices

I acknowledge that I have received, read, and understood the Notice of Privacy Practices. I know I have the right to request a copy of the full HIPAA acknowledgment that provides a complete description of how my health information may be used and disclosed. I also understand that Southwest Gastroenterology Associates reserves the right to change its Notice of Privacy Practices occasionally. I may contact them anytime to obtain a copy of the Notice of Privacy Practices. I know that I may request in writing to restrict how my information is used or disclosed to carry out treatment, payment, or healthcare operations. However, I understand that Southwest Gastroenterology Associates may not be required to comply with my request.

I, _____, have received a copy of this office's HIPAA policy.

_____ _____

Patient Name Guardian Printed Name (if applicable)

_____ _____

Patient Signature Guardian Signature

_____

Date

Office Use Only

I attempted to obtain the patient's signature in acknowledgment of this Notice of Privacy Practices Acknowledgement but was unable to do so, as documented below.

Date: Initials: Reason: