817 Lawn Avenue, Sellersville, PA 18960 215.453.3050

Patient Acknowledgement Form

Patient ____ **Date** _______________________

Our Notice of Privacy Practices provides information about how The Endoscopy Center may use and disclose Protected Health Information ("PHI") about you. The notice contains a Patient Rights section describing your rights under the law. Please review our Notice thoroughly before signing this Acknowledgement form. The terms of our notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how PHI about you is used or disclosed for treatment, payment, or health care operations. We are not required to comply with this request; however, we will make every effort to do so.

By signing this form, you acknowledge that The Endoscopy Center may use and disclose PHI about you for your treatment, payment and health care operations. The Endoscopy Center provides this form in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

The patient understands that:

- PHI may be disclosed or used for treatment, payment, of health care operations.
- The Endoscopy Center has a Notice of Privacy Practices and he/she has had the opportunity to review this notice.
- The Endoscopy Center reserves the right to change the Notice of Privacy Policies.
- He/she has the right to restrict the uses of their PHI but the Endoscopy Center does not have to agree to those restrictions.

This Acknowledgement is signed by: _________________________________ Date: _________________

Relationship to Patient (if other than patient): ____

Name of Patient (if signed by other than patient):____

Witnessed by: ____

Signature of Endoscopy Center Representative