Westside Gastroenterology Associates
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Acknowledgement of Receipt of "NOTICE OF PRIVACY PRACTICES" for Protected Health Information

I, acknowledge that I have received a copy of WESTSIDE GASTROENTEROLOGY ASSOCIATES "Notice of Privacy Practices" for Protected Health Information on the date set forth below.

Patient Name ____________________ Date of Receipt ____________________

____________________________________ ____________________________________

Print Name of Authorized Personal Representative | Signature of Authorized Personal Representative

Please Indicate Relationship to Patient ____________________

FOR USE BY WESTSIDE GASTROENTEROLOGY ASSOC. PERSONNEL ONLY: (Complete if Patient Acknowledgement is not obtained)

An Acknowledgement of Receipt of Notice of Privacy Practices was not obtained because:

[ ] Patient refused to sign Acknowledgement.

[ ] Unable to gain signed Acknowledgement due to communication/language or other barrier.

[ ] Patient was unable to sign Acknowledgement due to emergency treatment situation.

[ ] Other: Please indicate reason____

Signature of WESTSIDE GASTROENTEROLOGY ASSOCIATES Representative:_______________________________