

Gastrointestinal Associates of Rockland, PC

**NOTICE OF PRIVACY PRACTICE**  
**ACKNOWLEDGEMENT**

(After review of this document, please sign and return THIS PAGE ONLY to the receptionist)

I, \_\_\_\_\_, hereby acknowledge that I have received and reviewed the "Notice of Privacy Practices" which more fully describes the uses and disclosures that can be made of my individually identifiable health information for treatment, payment and healthcare operations.

\_\_\_\_\_  
Signature or Patient or Patient's Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name of Patient or Patient's Representative

\_\_\_\_\_  
If representative, specify Relationship