Richmond Gastroenterology Associates

Chart # _____

Written Acknowledgement Form

Our Notice of Privacy Practices provides information about how we may use and disclose Protected Health Information about you. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy.

I, _____ (Please print patient's name) have received a copy of Richmond Gastroenterology Associates,, Inc.'s Notice of Privacy Practices.

I have had an opportunity to read the Notice of Privacy Practices.

I understand that I may ask questions of Richmond Gastroenterology Associates, Inc. if I do not understand any information in the Notice of Privacy Practices.

Patient Signature: _____

Date: _____

☐ I agree that RGA may leave a voice mail message regarding tests results.

Phone # _____

Optional authorization:

Please complete this section only if you wish your medical and financial information to be discussed with anyone other than yourself.

I, _____ (patient's name) hereby authorize Richmond

Gastroenterology Associates, Inc. to discuss my Medical Health information with

_____. Their date of birth is: _____.
(Name of relative or friend)

Relationship to patient: _____

Patient Signature: _____ Date: _____