ISLAND VIEW GASTROENTEROLOGY ASSOCIATES

168 N. Brent Street, Suite 404, Ventura CA 93003
Phone: **805.641.6525** Fax: 805.641.6530

Patient Acknowledgement
Receipt of Privacy Notice

I, _____ hereby affirm that I have received a copy of the *Notice of Privacy Practices* from Island View Gastroenterology Associates. Under federal law 104-191, also known as HIPAA, I am entitled to receive a copy of this *Notice* from my healthcare provider.

I understand that my signature on this Acknowledgement only signifies that I have received a copy of the *Notice*, and does not legally bind or obligate me in any way.

I understand that I am entitled to receive a copy of the *Notice of Privacy Practices* from my healthcare provider, whether I sign this Acknowledgement or not.

Patient Name: _____

_____
Signature of Patient or Personal Representative

_____
Date

_____
Name of Personal Representative (if applicable)

_____
Description of Personal Representative's Authority (if applicable)

▼▼▼ FOR OFFICE USE ONLY ▼▼▼

Patient offered Notice of Privacy Practices but refused to sign acknowledgement ☐

Staff Signature:

Date:

Revised September 2013