Acknowledgement of Receipt of Notice

CT. GASTROENTEROLOGY ASSOCIATES, PC

Privacy Officer

Tel. 860-522-1171ext. 305

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices.

Name of Patient _____

□ I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices and that I may request a copy of any amended Notice of Privacy Practices at each appointment.

□"I acknowledge and agree that the Group will enter my protected health information ("PHI") in a database maintained by the Saint Francis Hospital and Medical Center (the "Hospital"). The PHI maintained in the database will be used by this Group for treatment, payment and health care operations purposes. The Group may also disclose your PHI maintained in the database to another provider (i) for treatment purposes, (ii) for payment purposes and (iii) for health care operations if you have or had a relationship with the other provider and only for the following reasons: (a) evaluation and development of clinical guidelines, provided that the obtaining of generalizable knowledge is not the primary purpose of any studies resulting from such activities; population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, contacting of health care providers and patients with information about treatment alternatives; and related functions that do not include treatment; or (b) reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, health plan performance, conducting training programs in which students, trainees, or practitioners in areas of health care learn under supervision to practice or improve their skills as health care providers, training of non-health care professionals, accreditation, certification, licensing, or credentialing activities; or (c) health care fraud and abuse detection or compliance. The Group may also disclose your PHI maintained in the database to the Saint Francis Health Care Partners ("SFHCP") for use by the SFHCP as a Business Associate of the Group for health care operational purposes, including without limitation, quality and utilization review health care services."

Yes No (circle one) I would like to receive a copy of any amended Notice of Privacy Practices by e-mail at: _____.

Signed: _____ Date: _____

Print Name: _____ Telephone: _____

If not signed by the patient, please indicate your relationship to the patient:

- ❑ parent or guardian of minor patient
- ❑ guardian or conservator of an incompetent patient
- ❑ beneficiary or personal representative of deceased patient

Name of Patient: _____

_____

***For Office Use Only*:**

- ❑ Signed form received by: _____
- ❑ Acknowledgment refused:

Efforts to obtain:

_____

Reasons for refusal:

_____