NEW YORK GASTROENTEROLOGY ASSOCIATES

Acknowledgment of Notice of Privacy Practices

This form confirms that you have received New York Gastroenterology Associates' (NYGA) Notice of Privacy Practices, which explains how NYGA may use and disclose your health information and your rights under HIPAA.

Acknowledgment

By signing below, I acknowledge that I have received New York Gastroenterology Associates' Notice of Privacy Practices.

_____ _____

Name of Patient Date

_____

Signature of Patient

_____ _____

Signature of Responsible Party (if applicable) Date

_____

Print Name of Responsible Party (if applicable)