Acknowledgement of Receipt of Notice of Privacy Practices

Summit Gastroenterology Associates, Inc. reserves the right to modify the privacy practices outlined in the notice.

I am aware of the PRIVACY NOTICE of Summit Gastroenterology Associates, Inc. and acknowledge I am entitled to a copy upon request.

Signature of Patient or Patient Representative **Date**

Authorization for Release of Information

Summit Gastroenterology Associates, Inc. will not release any information regarding your care, treatment or financial information to any other party without your authorization. **Unless listed below, we are unable to speak to anyone other than yourself for test results, billing information or any other inquiry made on your behalf.**

Their Name: **Relationship to you:**

I give permission to Summit Gastroenterology Associates, to speak to any of the above listed individuals regarding my care/treatment and/or results of testing. I further give my permission to speak to any of the above regarding billing my insurance, statements and amounts due on my account.

Signature Date Signed

Revised 07/21/03.06/20/06.revised3.23.11