Akron Digestive Disease Consultants, Inc.

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Acknowledgement of Receipt of Notice of Privacy Practices

& Permission to Share Health Information

Patient Name: ______________________________ Date of Birth: _____________

I have reviewed the Notice of Privacy practices this day.

Patient Signature: ____________________________________ Date:_____________

Authorized Representative: ______________________________ Date: ___________

Describe relationship to patient: ____

Notification of Family and Friends

I authorize Akron Digestive Disease Consultants to disclose my health information to the following:

☐ *Check here if you would like this to also include your billing information.*

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Name Phone

____

Name Phone

____

Name Phone

Patient Signature: __________________________________ Date:________________