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North Suburban Gastroenterology Associates, S.C

Receipt of Notice of Privacy Practices Form

I, _____, hereby acknowledge receipt of the physician's Notice of Privacy Practices. The Notice of Privacy Practice provides detailed information about how the practice may use and disclose my confidential information.

I understand that the physician has reserved a right to change his or her privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided to me or made available upon my request.

_____ _____

Patient Signature Date Staff Initials

_____ _____

Patient Name -Please Print DOB