Puget Sound Gastroenterology, PS Acknowledgement of
Receipt of Notice of Privacy Practices

By my signature below I, ________________________________, acknowledge that I received a
copy of the Notice of Privacy Practices for Puget Sound Gastroenterology, PS.

This form will be retained in your medical record.

X ________________________________ ______________________________
Signature of client (or personal representative) Date

If this acknowledgement is signed by a personal representative on behalf of the client, complete the
following:

Personal Representative’s Name: ________________________________

Relationship to Client: ________________________________

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For Office Use Only

I attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but
acknowledgement could not be obtained because:

☐ Individual refused to sign
☐ Communications barriers prohibited obtaining the acknowledgement
☐ An emergency situation prevented us from obtaining acknowledgement
☐ Other (Please Specify)

________________________________________
________________________________________
________________________________________

Employee Name ________________________________ Date ________________________________

Puget Sound Gastroenterology, PS
Eastside Gastroenterology, Edmonds Endoscopy Center, Evergreen Endoscopy Center, Fremont Endoscopy Center,
Puget Sound Gastroenterology at Edmonds, Puget Sound Gastroenterology at Mill Creek, Seattle Endoscopy Center,
Seattle Gastroenterology Associates, Seattle Histology Laboratory