GI Associates of Maryland

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ACKNOWLEDGE RECEIPT OF OUR NOTICE OF PRIVACY PRACTICES

GI Associates of Maryland reserves the right to modify the privacy practices outlined in the notice.

I have received a copy of the Notice of Privacy Practices and consent to the use and disclosure of patient health information only in accordance with HIPPA guidelines.

Name of Patient

Signature of Patient

Date

Signature of Patient Representative *(required if patient is a minor or an adult who is unable to sign)*

Relationship of Patient Representative to Patient