DIGESTIVE HEALTH CENTER OF MICHIGAN
DHCMI

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Notice of Privacy Practices Acknowledgement With Opportunity to Agree or Object

I acknowledge:

A copy of the Digestive Health Center of MI Notice of Privacy Practice was made available to me at the place where I went for health care services.

A copy of the Notice of Privacy Practices was made available for me to keep.

I received the notice of Privacy Practices the first day I received health care services at Digestive Health Center of MI.

Name of Patient: Date:

Signature of Patient or Representative: _____

Optional: Opportunity to Agree or Object

It is our practice to leave messages at your home regarding appointment reminders, prescription refills, or referral testing arrangements. (note: actual test results are NOT left as message.)

_____ YES, Leave messages on my answering machine or with the person who answers the phone.
_____ NO, Do not leave messages at my home, I prefer to be called at _____or contacted by mail at this address: _____.

I understand that my test results are private and will not be released to anyone other than myself unless I authorize it. I request that the following person has my consent to get my results,

NAME_____ Relationship _____

I understand that the above instructions will be in force until I notify the office of any changes.
Patients Initials _____