

\_\_\_\_\_  
Name of Patient (Please Print)

\_\_\_\_\_  
Date of Birth

**ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE**

I acknowledge that I received the Notice of Privacy Practices for Main Line Gastroenterology Associates, P.C. and Main Line Endoscopy Center, LLC.

I request that you attempt to contact me with confidential communications about my healthcare in the following way(s):

Leave messages on home answering machine? Yes  No  Phone # \_\_\_\_\_

Leave messages on voicemail at place of employment? Yes  No  Work # \_\_\_\_\_

Leave messages on cell phone? Yes  No  Cell # \_\_\_\_\_

E-mail? Yes  No  E-mail \_\_\_\_\_

Discuss my healthcare with family members? (Please specify)  
\_\_\_\_\_  
\_\_\_\_\_

Additional instructions \_\_\_\_\_  
\_\_\_\_\_

\*\*\*This request will remain in effect unless otherwise revoked in writing\*\*\*

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Personal Representative

\_\_\_\_\_  
Relationship to Patient