Carlisle Digestive Disease Associates, Ltd.
Carlisle Endoscopy Center, Ltd.
241 Alexander Spring Road
Carlisle, PA 17015

I understand that, under the health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payors.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice from time to time and I may contact this organization at any time to obtain a current copy of the Notice.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

You may contact me by mail at home and/or at the following address: _____

_____

You may contact me or leave a voice message at the following telephone numbers:

Home: _____
Work: _____
Cell: _____

You may discuss any portion of my medical record with the following people:

Name: _____ Relationship: _____
Name: _____ Relationship: _____
Name: _____ Relationship: _____

Patient Name: _____ Relationship to Patient: _____

Signature _____ Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement Form but was unable to do so as documented below:

Date:	Initials:	Reason:

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT