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Acknowledgement of Receipt of Notice of Privacy Practices
Advanced Gastroenterology of Texas, PLLC
Office of Farbod Masrour, D.O.

By signing below, I acknowledge that I have been provided a copy of the Notice of Privacy Practices Advanced Gastroenterology Texas, PLLC. Please initial each statement.

___ I have been advised of how health information about me may be used and disclosed by the practice.

___ I may obtain access to and control this information..

___ I understand that I can request an amendment if I feel my health or billing is incorrect.

___ I understand the practice has the right to deny my request for an amendment. I understand I have the right to make a statement of disagreement to be placed in my file.

___ I understand the practice may revise this Notice and I may request a copy of this Notice at any time.

___ I understand the practice maintains a current copy of this Notice on the practice website at www.advancedgastrodoc.com.

_____ _____
Print Patient Name Date

_____ _____
Signature of Patient or Guardian Relationship to Patient

Office Use Only

Employee Signature _____ Date _____

Comments _____