



# Advanced

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## Gastroenterology of Texas

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Acknowledgment of Receipt of Notice of Privacy Practices  
Advanced Gastroenterology of Texas, PLLC  
Office of Farbod Masrour, DO

By signing below, I acknowledge that I have been provided with a copy of the Notice of Privacy Practices of Advanced Gastroenterology of Texas, PLLC. Write your initials on 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 that will be placed in my file.

\_\_\_ I understand that 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 [www.advancedgastrodoc.com](http://www.advancedgastrodoc.com).

\_\_\_\_\_  
Print Patient's name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of patient or Legal Guardian

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

**Use only of office**

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_

Comments \_\_\_\_\_