Garden City Colon & Rectal
Surgical Practice, P.C.
1075 Franklin Avenue
Garden City, NY 11530

Notice and Acknowledgement

Acknowledgement:

I acknowledge that I have received the attached **Notice of Privacy Practices.**
I acknowledge that I have received the attached **Notice/Insurance Waiver.**

Patient's Signature ______________________________ **Date:** ________________________

Personal Representatives Section:

I, ________________________ permit the office of the **Garden City Colon & Rectal Surgical Practice, P.C.** to provide my health information to the following personal individuals on my behalf:

______________________________relationship to patient ____________________________

______________________________relationship to patient ____________________________

I understand that if I ever wish to revoke the right of any of the above representatives to obtain my health information on my behalf, I must notify the office of the **Garden City Colon & Rectal Surgical Practice, P.C.**, in writing that this individual is no longer my personal representative.

Patient's Signature ______________________________ **Date:** ____________________