



**PENINSULA
GASTROINTESTINAL
SPECIALISTS, INC**

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Acknowledgement of Receipt of Notice of Privacy Practices

To Our Patients:

In accordance with Federal Law on the Patient Privacy, please read the following:

This statement is to advise you that our office has a Privacy Policy (complete policy in waiting room) in place to protect your medical information. In brief, our policy states that our office will keep your medical record information confidential and will use it only for treatment, payment and healthcare operations. The office may release information to other doctors during emergencies, or cases of neglect and abuse. Our policy identifies your rights to access your records, request restrictions on who can see and be informed of your medical information. In short, to keep your communications with this office confidential.

Our Privacy Policy can be reviewed in its entirety, or you may request a copy.

Name: _____ Signature: _____ Date: _____

If not signed by the patient, please indicate relationship: _____

You have my permission to release my medical information to the following: *(please check and list name and phone number)*

- Patient Only
- Spouse/domestic partner: _____
- Others: _____

Would you like information regarding Advanced Directives? Yes
 No