Georgia Osteopathic Care Center

Acknowledgement of Receipt of Privacy Notice

By signing below, I acknowledge that I have been given the opportunity to read and receive a copy of the PCOM – GA's (Philadelphia College of Osteopathic Medicine – Georgia Campus) Privacy Notice.

_____

Patient or patient's representative (please print name)

_____ _____

Signature of patient or patient's representative **Date**

_____

Representative's relationship to the patient

Office Use Only

I attempted to obtain the patient's or representative's) signature on the Acknowledgement but did not receive it because:

☐ Patient refused to sign.

☐ This was an emergency treatment. Attempt will be made at the next visit to obtain signature.

☐ Patient was unable to sign because _____

_____

_____

Employee's name (please print)

_____ _____

Employee's signature Date