GA–PCOM

Georgia Osteopathic Care Center

Acknowledgment 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 Georgia Campus – Philadelphia College of Osteopathic Medicine's (GA-PCOM) Privacy Notice.

_____

Patient or patient's representative (please print name)

_____ _____

Signature of patient or patient's representative *Date*

_____

Representative's relationship to patient

Office Use Only

I attempted to obtain the patient's (or representative's) signature on the Acknowledgment but did not because:

_____ Patient refused to sign.

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

_____ Patient was unable to sign because: _____

_____

_____ Other (please explain): _____

_____

_____

Employee's name (printed)

_____ _____

Employee's signature *Date*