

PCOM Healthcare Centers

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 Philadelphia College of Osteopathic Medicine's (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 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