

Atlanta Midtown Gynecology INC

Acknowledgement of Receipt  
Of  
“Notice of Privacy Practices”  
For Protected Health Information

I acknowledge that I have received a paper copy and/or reviewed a copy on the website of Atlanta Midtown Gynecology’s “Notice of Privacy Practices” for protected health information on the date set forth below and understood the notice.

\_\_\_\_\_  
Date of Receipt

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Name of Authorized Personal Representative if other than patient

\_\_\_\_\_  
Signature of Authorized Personal Representative

=====Office Use Only=====

Office Staff to complete if patient Acknowledgement is not obtained

\_\_\_\_\_ Patient refused to sign acknowledgement

\_\_\_\_\_ Unable to gain signed acknowledgement due to communication/language barrier

\_\_\_\_\_ Patient was unable to sign acknowledgement due to emergency treatment situation

\_\_\_\_\_ Other reason:\_\_\_\_\_

\_\_\_\_\_  
Signature of Atlanta Midtown Gynecology Representative

\_\_\_\_\_  
Date

