

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

