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