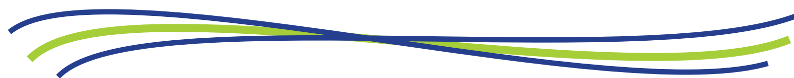

Form of Written Acknowledgment of Receipt of Cobb Medical Associates Notice of Patient Privacy Practices

By signing this Written Acknowledgment of receipt of **Cobb Medical Associates** Notice of Patient Privacy Practices ("Acknowledgment"), I hereby expressly acknowledge my receipt of **Cobb Medical Associates** Notice of Patient Privacy Practices.

____
Patient or Legal Representative, Signature

____
Patient or Legal Representative, Printed Name

____
Date

Acknowledgment **NOT** obtained because:
___ Patient or Legal Representative declined Notice of Patient Privacy Practices

___ Patient treated in Emergency Room and discharged before obtaining Acknowledgment

___ Other (Briefly Describe)

____

____

____

____
Employee Signature

____
Employee Printed Name

____
Date

3903 South Cobb Drive Suite200 Smyrna, Georgia 30080-6300 www.cobbmedicalassociates.com