

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*By Signing below, I acknowledge that I am aware of Oconee Urology, P.C.'s Notice of Privacy Practices. I also acknowledge that I may request a copy of Oconee Urology, P.C. Notice of Privacy Practice, that I may view it on their website at <http://www.oconeeurology.net>, or that I may view it posted in their waiting room.*

\_\_\_\_\_  
Signature of patient or personal representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
If signed by personal representative, relationship to patient.  
\_\_\_\_\_

Office Use Only:

Oconee Urology, P. C. has made a good faith effort to obtain a written acknowledgement of receipt of the Notice provided to the individual named below.

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

Refused to Sign:  Physically unable to Sign:

Other:  Reason stated below:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Employee Signature: \_\_\_\_\_

Date: \_\_\_\_\_