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: _____