Colonial
INTERNAL
MEDICINE
Associates

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY

I have received or have been offered a copy of the notice of Privacy Practices. Colonial Internal Medicine Associates, P.C., reserves the right to modify the privacy practices outlined in the notice

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Printed Name of Patient

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Signature of Patient

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Date

____
Signature of Patient Representative
(Required if patient is a minor or an adult who is unable to sign this form)

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Relationship of Patient Representative to Patient