PIEDMONT MEDICAL
ASSOCIATES

Acknowledgement of Receipt of "Notice of Privacy Practices"

☐ I hereby acknowledge that I received a copy of

Piedmont Medical Associates "Patient Notice of Privacy Practices"

_____

First and Last Name of Patient

_____

Signature of Patient or Patient Authorized Representative **Current Date & Current Time**

———————— OR ————————

Certification of Good Faith Efforts to Obtain Patient Acknowledgement

☐ I hereby certify that as an employee or agent of Piedmont Medical Associates, I have made a good faith effort to obtain from the patient or an authorized representative of the patient a written acknowledgement of Piedmont Medical Associates Physicians "Notice of Privacy Practices" in compliance with the practice policy known as "Notice of Privacy".

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First and Last Name of Staff or Agent of Piedmont Medical Associates

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Signature of Staff or Agent of Piedmont Medical Associates Current Date & Current Time

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Brief reason for not obtaining "Patient Notice of Privacy"

Piedmont Medical Associates: Cynthia Hurley, MD • David Scurlock, MD
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