COLORECTAL PHYSICIANS & SURGEONS OF PENNSYLVANIA
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ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

Patient Name: ___________________ Date of Birth: _____________

I acknowledge that I have received a copy of Saint Vincent Health System's Notice of Privacy Practices.

** If the patient is a minor or unable to complete the form, the parent/guardian or legal representative should sign as the patient's Personal Representative*

Patient Signature: ____________________________________

Printed Name: ____________________________________

Date: ________________

OR

Signature of Personal Representative _________________________

Printed Name: ____________________________________

Date: ________________

If Personal Representative's signature appears above, please describe Personal Representative's relationship to the patient.

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