MID-SOUTH
GASTROENTEROLOGY
GROUP

Phillip R. Bowden, M.D., P.A.

Acknowledgement of Receipt of Notice

I hereby acknowledge that I received copies of the Notice of Privacy Practices and Patient information including Patient's Rights and Responsibilities.

Signed _____ Date_____

Print name _____ Telephone _____

Email address _____

If not signed by the patient please indicate Relationship

_____Guardian or conservator of an incompetent patient

Patient's name _____

FOR OFFICE USE ONLY

Signed form received by_____

Acknowledgement refused

Efforts to obtain_____

_____

Reason for refusal _____

_____

Revocation Section

I hereby revoke this authorization

_____ _____

SIGNATURE DATE

_____ _____

AUTHORIZED PERSON RELATIONSHIP

_____ _____

PATIENT'S SIGNATURE DATE

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