

**Comprehensive Breast Care Center of West Georgia**

**ACKNOWLEDGEMENT OF RECEIPT OF OUR  
NOTICE OF PRIVACY PRACTICES**

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy upon request.

By signing below, you acknowledge that you have received a copy of our Notice of Privacy Practices on the date indicated below.

Patient Name \_\_\_\_\_

Patient/Responsible Party Signature \_\_\_\_\_

Date \_\_\_\_\_