

**ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES**

I have reviewed the Notice of Private Practices for Georgetown OB/GYN, LLP which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

\_\_\_\_\_  
Printed Name of Patient

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Description of Personal Representative's Authority