



**TRIPLE O MEDICAL
S E R V I C E S P A.**

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Acknowledgement of Receipt of Privacy Policy

The undersigned has read and understands the Privacy Policy of Triple O Medical Services, P.A. and acknowledges receipt of this policy.

Signature – Patient or Authorized Representative

Date

Representative Relationship to Patient

Printed Name

Office Use Only:

Chart Number _____

OR

I attempted to obtain patient's signature, however he/she refused to sign this form.

Reason for refusal: _____

Employee Name: _____

Employee Signature: _____

Date: _____