HEALTH CARE PARTNERS OF SC, INC.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

MRN_____

Printed Patient Name:_____ Patient DOB:_____

I hereby acknowledge that I have been offered or have received the HIPAA Notice of Privacy Practices document.

_____ Date: _____
Signature of Patient or Patient's Representative/Parent/Legal Guardian

_____
Signature of Patient or Patient's Representative/Parent/Legal Guardian

_____
Relationship to Patient

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

_____Individual refused to sign
_____Communication barriers prohibited obtaining the acknowledgement
_____An emergency situation prevented us from obtaining acknowledgement
_____Other (Please Specify)

_____
_____
_____
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