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 HIPPA 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.
_____ Communications barriers prohibited obtaining the acknowledgement.
_____ An emergency situation prevented us from obtaining acknowledgement.
_____ Other (Please Specify).

_____

_____

_____

_____

_____

_____