*Family Care Associates of Effingham, S.C.*

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# Receipt of Notice of Privacy Practice

I hereby acknowledge receipt of the physician's **Notice of Privacy Practices** for:

| | | | |
|---|---|---|---|
| _____ | | _____ | |
| Patient's Name | DOB | Patient's Name | DOB |
| _____ | | _____ | |
| Patient's Name | DOB | Patient's Name | DOB |
| _____ | | _____ | |
| Patient's Name | DOB | Patient's Name | DOB |

The Notice of Privacy Practice provides detailed information about how the practice may use and disclose my confidential information.

I understand that the physician has reserved a right to change his or her privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided to me by mail, in person or made available via internet/website.

Signature: _____ Date: _____

**If you are not the patient, specify your relationship to the patient_____.**

***Revised 1/14/2020***