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
(Patient's Name)

of Privacy Practices. 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.

Print Name: _____ DOB: _____

Signature: _____ Date: _____

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

Revised 1-2013