

Carolina Medical Consultants, PA
311 Glenwood Drive
Rock Hill, SC 29732

Acknowledgement of Notice of Privacy Practices

This notice describes how medical/protected health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Summary:

By law, we are required to offer you our Notice of Privacy Practices. This Notice describes how your medical information may be used and disclosed by us. It also tells you how you can obtain access to this information.

As a patient, you have the following rights:

1. The right to inspect and copy your information;
2. The right to request corrections to your information;
3. The right to request that your information be restricted;
4. The right to request confidential communications;
5. The right to a report of disclosures or your information; and
6. The right to a paper copy of this Notice.

In the event a physician or medical facility requests my Protected Health Information for the purpose of continuation of care, I authorize Carolina Medical Consultants to release all medical records including information relating to drug, alcohol, psychiatric conditions, and/or sexually transmitted disease, including HIV/AIDS information. I agree to allow this practice to leave medical information on my answering machine when needed.

We want to assure you that your medical/protected health information is secure with us. This Notice contains information about how we will insure that your information remains private.

If you have any questions about this Notice, our contact information is listed on this page.

Termination Date of this Notice : Does not Terminate
Contact : Carolina Medical Consultants Employee
Contact Number: 803-366-7175

Acknowledgement of Notice of Privacy Practices

"I hereby acknowledge that I have been offered a copy of the practice's **Notice of Privacy Practices**. I understand that if I have questions or complaints regarding my privacy rights that I may contact this practice. I further understand that the practice will offer me updates to this **Notice of Privacy Practices** should it be amended, modified, or changed in any way."

Patient Name (please print)

Patient or Representative Signature

Date

____ Patient refused to sign

____ Patient was unable to sign because _____.