

PATIENT ACKNOWLEDGMENT AND CONSENT

I have been given a copy of Carolina Internal Medicine Associate's Notice of Privacy Practices, version effective 01-01-2014. I consent to the uses and disclosures of my health information as outlined in the Notice.

Signature of Patient or Representative

Date

Print Name

Relationship of Representative to Patient

Please describe the Representative's authority to act on behalf of Patient: _____

FOR Carolina Internal Medicine Associates USE ONLY

If acknowledgment of receipt of the Notice of Privacy Practices is not obtained from the patient or the patient's representative, please explain your efforts to obtain acknowledgment and the reason you could not obtain it:

KAK