ACKNOWLEDGMENT FORM

We are required by law to provide you with our Notice of Privacy Practices which explains how we use and disclose your health information. We are also required to obtain your signature acknowledging that this notice has been made available to you.

☐ I have been provided a copy of CHS' Notice of Privacy Practices.

Signature_____Date_____
(Patient or Authorized Representative)

Relationship to Patient_____

Reason Patient Unable/Unwilling to sign_____

_____

Addressograph

CAROLINAS HEALTHCARE SYSTEM
Written Acknowledgment

File-Medical Records