



Carolinan Physicians Network  
Carolinan HealthCare System

ACKNOWLEDGEMENT FORM

Medical Records # \_\_\_\_\_

Patient's Name: \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_  
Day Month Year

We are required by law to provide you with our Notice of Privacy Practices which explain 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.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Patient or Authorized Representative)

Relationship to Patient: \_\_\_\_\_ Self \_\_\_\_\_ Spouse \_\_\_\_\_ Other \_\_\_\_\_

Reason Patient Unable/Unwilling to Sign: \_\_\_\_\_  
\_\_\_\_\_

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DOCUMENTO DE RECONOCIMIENTO DE CAROLINAS PHYSICANS NETWORK

Numero de Registro Medico \_\_\_\_\_

Nombre del Paciente \_\_\_\_\_ Fecha de Nacimiento \_\_\_\_/\_\_\_\_/\_\_\_\_  
Dia Mes Ano

La ley nos requiere que nosotros le proveamos a usted con nuestro Aviso de Practicas de Privacidad las cuales explican como podemos usar y divulgar su informacion medica. La ley tambien nos requiere que obtengamos su firma, reconociendo que este aviso lo hemos hecho disponible para usted.

Firma: \_\_\_\_\_ Fecha: \_\_\_\_\_  
(Paciente o Representante Autorizado)

Relacion al Paciente: \_\_\_\_\_ Mismo \_\_\_\_\_ Esposo (a) \_\_\_\_\_ Otro \_\_\_\_\_

Razon Por la Cual El Paciente No Puede/No Desea Firmar: \_\_\_\_\_