



## Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name
Address

**A representative from Carolina Ear and Hearing Clinic, PC may:**

- Leave a message on my answering machine/voicemail  YES  NO
- Speak with a family member in my home about my care  YES  NO
- Speak with family member calling our office concerning my care  YES  NO

**Your signature below is only an acknowledgement that you have received this Notice of Privacy Practices:**

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Patient Signature      Date

<b>For Office Use Only</b>	
<b>We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:</b>	
<input type="checkbox"/> An emergency existed & a signature was not possible at the time. <input type="checkbox"/> The individual refused to sign. <input type="checkbox"/> A copy was mailed with a request for a signature by return mail. <input type="checkbox"/> Unable to communicate with the patient for the following reason:	
Prepared By:	
Signature:	Date: