LOWCOUNTRY
Women's Specialists
WE TAKE CARE OF YOU FOR LIFE

Christopher R. Accetta, M.D.
William M. Reeves, III. M.D.
Christine L. Hunter, M.D.
Ronnie M. Givens, II. M.D.
Jennifer J. Heinemann, M.D.
Hunter A. Smith, M.D.
Martha A. Cohen, M.D.

NOTICE OF PRIVACY PRACTICES
ACKNOWLEDGEMENT OF RECEIPT

This is to acknowledge that I have received a copy of this office's Notice of Privacy Practices.

FULL NAME (Print): _____

SIGNATURE: _____ DATE: _____

If a personal representative or guardian signs this consent on behalf of the patient, please complete the following:

_____

REPRESENTATIVE/GUARDIAN'S FULL NAME RELATIONSHIP TO PATIENT

Unless I revoke this consent in writing, I give unrestricted access to my health records through verbal and written communication to the persons listed below.

_____

NAME DATE

FOR OFFICE USE ONLY

Our office attempted to obtain written acknowledgement of the patient's receipt of our Notice of Privacy Practices. We were unable to do so because:

- € Individual refused to sign
- € Communication barriers prohibited obtaining the acknowledgement
- € An emergency prevented us from obtaining acknowledgement
- € Other (Please Specify)_____

Updated: 6/30/2020