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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Urology Specialists of the Carolinas, PLLC has provided me its Notice of Privacy Practices for review.

I understand that the purpose of this notice is to inform me of my rights pertaining to my Protected Health Information ("PHI") and also the ways in which Urology Specialists of the Carolinas may use or disclose my PHI.

\_\_\_\_\_  
Patient's (or Legal Representative's) Signature Date

Patient Name \_\_\_\_\_

Chart Number \_\_\_\_\_

Date \_\_\_\_\_

In lieu of patient signature, I, \_\_\_\_\_, a staff member of Urology Specialists of the Carolinas, PLLC, state that the above-named patient has been given our current Notice of Privacy Practices.

\_\_\_\_\_  
Name Date

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