

Carson Family Care Center

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**Notice of Privacy Practices for Protected Health Information
(HIPAA)**

**Patient Acknowledgement of Receipt of the Notice of Privacy Practices for
Protected Health Information (HIPAA)**

I acknowledge receipt of the Notice of Privacy Practices for Protected Health Information (HIPAA) for Carson Family Care Center.

Signature

Date

Print Name of Patient

If you are signing as the patient's representative:

Print your name:

Describe how you are the patient's representative
(for example: spouse, child, durable power of attorney for healthcare, etc.)

Effective Date: March 1, 2013