UNIVERSITY OF SOUTH CAROLINA
SCHOOL OF MEDICINE
UNIVERSITY SPECIALTY CLINICS

By signing below, I state that I have been given my own copy of the University Specialty Clinics' Notice of Privacy Practices, effective date 8/20/13.

_____

Printed Name of Patient

_____ _____

Signature of Patient **Date**

OR

_____

Printed Name of Patient's Representative

_____ _____

Signature of Patient's Representative **Date**

_____

Description of Authority to Act on Behalf of Patient