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 4/14/03.

_____
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