Island Neuropsychology, LLC
Pediatric Neuropsychology
2113 Middle Street, Suite 301
Sullivan's Island, SC 29482
(843) 885-8087

Acknowledgement of Receipt of our Notice of Privacy Practices

By signing below, I acknowledge that I have been provided with a copy of the Island Neuropsychology, LLC. Notice of Privacy Practices. I, therefore, been advised of how private health information about me/my child may be used and disclosed by Island Neuropsychology, LLC and how I may obtain access to and control this information.

_____
Signature of Patient, Parent or Guardian

_____
Print Name of Patient, Parent or Guardian

_____
Date

_____
Designate if Signed by Patient, Parent or Guardian

(This section will be completed only if the written acknowledgement is not obtained)

Island Neuropsychology, LLC has made a good faith effort to obtain an individual's acknowledgement, but the acknowledgement was not obtained for the following reason(s):

_____ The individual refuses to sign or otherwise fails to provide an acknowledgement.

_____ The individual was mailed a copy of the Notice and did not mail back his/her receipt of acknowledgement.

_____ Other: _____

Completed by: _____

Date: _____