Notice of Privacy Practice

I acknowledge that I have received the "HIPAA Notice of Privacy Practices" from Carilion Clinic Specialty Pharmacy and that I have been provided an opportunity to review it.

By signing this form, I understand that I have certain rights to privacy regarding my protected health information.

Signature:_____ **Date**_____
(MM/DD/YYYY)

For more information on Carilion Clinic's Privacy Policy, please visit CarilionClinic.org/privacy-policy. You can return this signed form by either mail, fax or email.

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Fax: 540-769-2002

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