

**ATLANTA NEUROLOGY, PC**

**RECEIPT OF NOTICE OF PRIVACY PRACTICES  
WRITTEN ACKNOWLEDGEMENT FORM**

I, \_\_\_\_\_,

*Patient Name*

have been made available a copy of Atlanta Neurology's Notice of Privacy Practices.

I have the right to review the Notice of Privacy Practices prior to signing this Acknowledgement Form. I understand that the privacy practices described in the Notice of Privacy Practices may change over time, and that I have the right to obtain any revised Privacy Notice, if requested.

\_\_\_\_\_  
*Signature of Patient OR Legal Guardian*

\_\_\_\_\_  
*Date*

**To be maintained in Patient's permanent medical record**