

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