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