

ATLANTA NEUROLOGICAL ASSOCIATES, P.C.

Atlanta Neurological Associates, P.C. is a healthcare provider and will share my health information for treatment, payment and healthcare operations, including to my primary care physician. I have been provided access to the Notice of Privacy Practices that describes how my health information is used and shared. I also have access to a copy of these rights to retain for my records. I understand that Atlanta Neurological Associates, P.C. has the right to change this notice at any time. I may obtain a current copy by contacting the Privacy Officer at 404-522-6700.

My signature below constitutes my acknowledgement that I have been provided access to the Notice of Privacy Practices.

Patient/Legal Guardian/Relative Signature	Date	Relationship to Patient
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If any person is physically unable to provide a signature OR signs with a mark, print his/her name on the appropriate line above and record the signatures of two responsible persons who witness that such person understands the nature of this acknowledgement on the line below.

Witness	Date	Witness	Date
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If patient is not capable of acknowledging the notice because of age or medical condition, complete the following:
Patient is a minor (_____years of age) OR patient is unable to acknowledge because

- I authorize Atlanta Neurological Associates, P.C. to leave a message on my answering machine/voice mail with results information.
- I authorize Atlanta Neurological Associates, P.C. to have conversations pertaining to my Protected Health Information in front of anyone who accompanies me into the exam room.
- I authorize Atlanta Neurological Associates, P.C. to include the following person(s) in any conversations regarding my Protected Health Information:

Name	Relationship
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Name	Relationship
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Name	Relationship
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Signature of Patient or Guardian	Date
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