ADVANCED NEUROLOGIC ASSOCIATES, INC.

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HIPAA NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

The Health Insurance Portability and Accountability Act (HIPAA) require our office to make available to me a Notice of Privacy Practices that explains my rights regarding the privacy and confidentiality of my patient health information. I have received this Notice and am aware that any questions regarding this notice should be directed to the Privacy Officer:

Print Name: ____
(Patient Name)

Signature: ____ Date ____________________
(Patient or Responsible Party Signature)

Relationship to Patient ____________________________________

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With understanding the new HIPAA laws, I do realize that my health information cannot be shared with family members and or friends without my written consent. In understanding this, I would like my information to be shared with the following people:

______________________________________ ______________________________________
(Name / Relationship / Phone Number) (Name / Relationship / Phone Number)

______________________________________ ______________________________________
(Name / Relationship / Phone Number) (Name / Relationship / Phone Number)

Signature: ____ Date ____________________
(Patient or Responsible Party Signature)