Advanced Neurologic Associates, Inc.

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HIPAA NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

The Health Insurance Portability and Accountability Act (HIPAA) requires Advanced Neurologic Associates, Inc. to make available to me their 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.

_____ _____

PATIENT NAME (PLEASE PRINT) **PATIENT SIGNATURE** (PATIENT OR RESPONSIBLE PARTY)

_____ _____

RELATIONSHIP TO PATIENT **DATE**

With understanding of the HIPAA laws, I do realize that my health information cannot be shared with anyone without my written consent. I understand that this written consent will be in place until a written notice is given to Advanced Neurologic Associates, Inc. to remove it. 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)