



**PATIENT ACKNOWLEDGEMENT OF
NOTICE OF PRIVACY PRACTICES**

As Required by the Privacy Standards of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

I have received a copy of the Notice of Privacy Practices of ATLANTA BRAIN & SPINE CARE on the date indicated below.

I understand that if any changes are made to this Notice of Privacy Practices, a revised copy of the Notice will be posted in the offices of ATLANTA BRAIN & SPINE CARE.

I also understand that if I wish to receive additional copies of this Notice of Privacy Practices in the future or if I have any questions with regard to this Notice of Privacy Practices, I may contact:

**Compliance Officer
ATLANTA BRAIN & SPINE CARE
2001 Peachtree Road, N.E.
Suite 575
(404) 350-0106
(404) 350-0176 Fax**

Signature of Patient

PRINT NAME: _____

DATE: _____