



PATIENT ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

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

Atlanta Brain and Spine Care's Notice of Privacy Practices is located on our web site www.atlantabrainandspine.com. A copy is available in our office or you may request a copy.

I have read a copy of the Notice of Privacy Practices of ATLANTA BRIAN & 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 BRIAN & 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: _____