Georgia Neurology & Sleep Medicine

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, **[name of patient]** _____, acknowledge and agree that I have received a copy of **Georgia Neurology & Sleep Medicine**'s Notice of Privacy Practices.

_____	_____
Patient Signature	Date
_____	_____
Patient Legal Representative (if applicable)	Date
_____	_____
Print Name of Legal Representative	Relationship to patient

FOR CLINIC USE ONLY:

Georgia Neurology & Sleep Medicine made the following good faith efforts to obtain the above-referenced individual's written acknowledgement of receipt of the Notice of Privacy Practices:

[Identify the efforts that were made to obtain the individual's written acknowledgement, including the reasons (if known) why the written acknowledgement was not obtained.]