



NEUROLOGY & NEUROSCIENCE ASSOCIATES, INC.

**ACKNOWLEDGEMENT OF RECEIPT OF NNA'S
NOTICE OF PRIVACY PRACTICES**

(a complete copy of NNA Privacy Policy available upon request at your initial visit)

I, (print) _____ have been offered immediate access to review the Notice of Privacy Policies for Neurology and Neuroscience Associates, Inc.

Patient Signature: _____

Birth Date: _____ Date: _____

I authorize NNA to discuss and/or release my medical and billing information with the following individuals:

Name:	Relationship:

Signature: _____ Date: _____