



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

Are you your own legal guardian? ___Yes ___No If no, please see below:

If you have answered NO to the above question or you are a minor whose guardian is other than a parent, we will need copies of the Power of Attorney and/or Guardianship Papers to be on file.

Please check appropriate box below:

I do **NOT** authorize NNA to discuss medical and billing information with any family member and/or friends.

I **authorize** NNA to discuss my medical and billing information with the individuals (family/friends) that I have listed below.

Name	Relationship	Phone number

Patient Signature: _____

Birth Date: _____ Date Signed: _____