NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

General & Vascular Surgery of NW AL, Inc.

I understand that under the Health Insurance Portability and Accountability Act (HIPPA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received of have been given the opportunity to receive a copy of your **Notice of Privacy Practices**. I also understand that this practice has the right to change its **Notice of Privacy Practices** and that I may contact the practice at any time to obtain a current copy of the **Notice of Privacy Practices**.

_____ _____

Patient Name or Legal Guardian Date

_____

Signature

I give Dr. Manord's office staff permission to leave detailed messages for me and also give permission for my accounting records, insurance information, and for medical records to be discussed with the following individuals:

_____ _____

Name Relationship to Patient

_____ _____

Name Relationship to Patient

_____ _____

Name Relationship to Patient

Patient Initials: _____

Office Use Only

We have made the following attempt to obtain the patient's signature acknowledging receipt of the Notice of Privacy Practices:

_____ _____

Date Attempt

Staff Name: _____