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PRIVACY PRACTICES ACKNOWLEDGMENT

I have had the opportunity to read and review the content of this authorization form and I agree with all statements made in this authorization. I understand that, by signing this form, I am confirming my authorization for use and/or disclosure of the protected health information described in this form with the people and/or organizations named in this form.

Signature: _____ Date: _____

If this authorization form is signed by a personal representative for the individual patient:

Personal Representative's Name: _____
Print Name

Relationship to Individual Patient: _____

YOU HAVE A RIGHT TO HAVE A COPY OF THIS FORM AFTER YOU SIGN IT.

Submit the authorization to the Privacy Official and include a copy in the individual patient's medical record.

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name: _____ Birthday: _____

Signature: _____

Date: _____