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ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

As Required by the Privacy Standards of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

I have received a copy of the **Notice of Privacy Practices** of Athens Spine Center on the date indicated below.

I understand that if any changes are made to this **Notice of Privacy Practices**, a revised copy of the **Notice** will be posted in the offices of Athens Spine Center.

I also understand that if I wish to receive additional copies of this **Notice of Privacy Practices** in the future or if I have any questions with regard to this **Notice of Privacy Practices**, I may contact:

Athens Spine Center Administrator
855 King Avenue
Athens, Georgia 30606
706-425-2400
706-425-2410 FAX

Signature of Patient

Print Name: _____

Date: _____

THIS SPACE TO BE USED BY PRACTICE ONLY.

DATE ACKNOWLEDGEMENT DENIED BY PATIENT: _____

REASON DENIED BY PATIENT: _____

NAME OF PERSON REVIEWING DENIAL: _____

DATE: _____