ACKNOWLEDGEMENT OF RECEIPT
INFORMATION PRIVACY PRACTICES
INTERNAL MEDICINE SPECIALISTS OF ATLANTA, P.C.

I acknowledge that I have received and reviewed the information privacy practices for Internal Medicine Specialists of Atlanta, P.C. I understand that I may request a paper copy of the same at anytime and that I may access the practices at anytime on the practice website (www.thedoctorsarein.com).

I wish to exclude release of my privileged health information to the following person or entity:
(if no exclusions, please write NONE)

_______________________________________ _________________________

Printed Name **Date of Birth**

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Signature

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Date