

Patient Name: _____

Patient Number: _____

**The Surgical Suite
Privacy Practices Notices Acknowledgement**

By my signature below, I am acknowledging that I may request a copy of The Surgical Suite's (a division of Dermatology Associates of Atlanta, PC) privacy policy as required by the Privacy Regulations created as a result of the H e a l t h i n s u r a n c e o f t h e U n d e r h e l d i n g o f t h e H e a l t h i n s u r a n c e o f t h e A c c o n t a b i l i t y A c t o f 1 9 9 6 (HIPAA).

The notice of privacy practices states that:

- We are committed to your privacy
- We may use and disclose your P r o t e c t e d H e a l t h i n f o r m a t i o n (PHI) in certain ways described in the Notice of Privacy Practices
- You have rights. You may receive a copy of your medical information and may request in writing, that we not disclose your medical information to a certain person or persons
- You may contact our Privacy Officer at any time you wish to discuss a concern

I wish to exclude the following person, persons or organizations from receiving any information in regard to my Protected Health Information _____.

Patient Signature: _____ Date: _____

Witness: _____