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 Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The notice of privacy practices states that:

- We are committed to your privacy
- We may use and disclose your Protected Health Information (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:_____