



PATIENT 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 The Doctor's Office, LLC 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 The Doctor's Office, LLC.

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:

**Compliance Officer
The Doctor's Office, LLC
1065 Jodeco Road
Stockbridge, Georgia 30281
678-284-6300
678-284-6336 Fax**

Signature of Patient

PRINT NAME: _____

DATE: _____