ACKNOWLEDGMENT OF PRIVACY NOTICE and DESIGNATION OF PERSONAL HEALTHCARE REPRESENTATIVE

By signing below I understand that NOTICE OF PRIVACY POLICIES FOR ASSOCIATES IN NEUROLOGY, P.C. detailing how my protected health information may be used and disclosed as permitted under federal and state law is posted in each office maintained by Associates in Neurology, P.C. I have the right to obtain a paper copy of this notice of protected health information practices upon request and I understand the contents of the notice. If I so choose, individuals or agencies that I would like to be given all privileges that would be given to me with respect to my protected health information are listed below.

CHOOSE ONE OF THE FOLLOWING:

_____ I do not wish to designate a personal healthcare representative with respect to my protected health information at this time.

_____ I hereby grant permission to Associates in Neurology, P.C. to disclose my protected health information to:

______________________	______________________	(______)______________
Printed name	Relationship to patient	Phone number
______________________	______________________	(______)______________
Printed name	Relationship to patient	Phone number

PATIENT SIGNATURE: ______________________ DATE: ____________

Printed name of patient: ______________________

Responsible party signature: ______________________ Date: ____________
(If other than patient)

Printed name of responsible party: ______________________

Witnessed by: ______________________
Associates in Neurology, P.C. representative

POWER OF ATTORNEY

If patient has legally designated a HEALTHCARE POWER OF ATTORNEY please provide information below.

______________________	______________________	(______)______________
Printed name of Legal Guardian	Relationship to patient	Phone number

AIN OFFICE USE: ON FILE _____ NEED COPY_____

GUARDIANSHIP

If patient has an appointed LEGAL GUARDIAN please provide information below.

______________________	______________________	(______)______________
Printed name of legal guardian	Relationship to patient	Phone number

AIN OFFICE USE: ON FILE _____ NEED COPY_____