SNORING DIAGNOSTIC
CENTER OF ATLANTA

HIPAA Acknowledgement

Notice of Privacy Practices

Printed Name of Patient: ____

Patient Date of Birth: ____

I acknowledge receipt of Advocare's Notice of Privacy Practices.

Signature of Patient/Legal Representative: ______________________________ Date: ______________

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Office Use:

To be completed only if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement, and the reason why the acknowledgement was not obtained.

Reason: ____

Signature of Representative: ____ Printed

Name: ______________________________________ Date: ______________________