Atlantic Urology
medical group

PF-3000 (b) NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting your office's Practice Administrator.

Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information.

I AUTHORIZE MY INFORMATION TO BE DISCLOSED TO THE FOLLOWING:

Name of person/organization	Relationship to patient
Name of person/organization	Relationship to patient
Name of person/organization	Relationship to patient

By my signature below, I acknowledge receipt of the Notice of Privacy Practices.

____ __________________________

Patient Name (print) Medical Record #

____ __________________________

Signature of patient or legally authorized individual Date & Time

____ __________________________

Printed Name if signed on behalf of the patient Relationship to Patient

Notation by staff: