Acknowledgment of Receipt of *Notice of Privacy Practices*

With your approval, your protected health information may be used and disclosed for treatment, payment, or health care operations.

By your signature below, you acknowledge that you have received the Abay Neuroscience Center, LLC ("Abay") Notice of Privacy Practices for Protected Health Information ("Privacy Notice") which provides a complete description of the uses and disclosures that the Abay office/staff may use of your protected health information, as well as your rights in relation to such information.

Abay has reserved the right to change its privacy practices described in its Privacy Notice. In accordance with law, the terms of the Privacy Notice may change. At any time, you may obtain a copy of the current Privacy Notice and any revised notice by requesting the Privacy Notice in writing or by requesting a notice in person.

_____ _____ _____

Name Signature of Patient Date

Or _____ _____

Signature of Personal Representative of Patient Description of Representative's Authority to Act for Patient

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Authorization When Patient Requests Use or Disclosure of Protected Health Information

I hereby authorize Abay Neuroscience Center to disclose any of the following information: Any medical treatment regarding billing issues, appointment concerns, and medical records related to my care as if I were the person calling or inquiring. **Please list the name and relationship of the people you wish to have this access (Such as family members or friends).**

NAME	RELATIONSHIP	PHONE

This authorization will expire upon my release from ANC to my primary care physician/referring physician (List date or event). I understand I have a right to revoke the authorization in writing except to the extent Abay Neuroscience Center has taken action or has relied on the authorization. This authorization may be revoked by my requesting revocation in writing and delivering a copy of the same to Abay Neuroscience Center.

The information used or disclosed under the authorization may be subject to redisclosure by the recipient and no longer protected by federal privacy laws.

_____ _____

Signature of Patient Date

_____ _____

Signature of Personal Representative or Patient Date