NEW YORK
Epilepsy&Neurology
PLLC

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

By signing below, I acknowledge that I have been provided a copy of the Notice of Privacy Practices as required by the Health Insurance Portability and Accountability Act (HIPAA). In this notice I was advised of how health information about me may be used and disclosed by NY Epilepsy and Neurology, PLLC physicians and staff. I was also told how I may obtain a copy of this information and correct errors in my health information.

_____
Print Name of Patient

_____
Signature of Patient (or Financially Responsible Party)

_____
Relationship to Patient

_____
Date