Michigan Advanced Neurology Center

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RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

I understand I have the right to review Dr. Mridha's "Notice of Health Information Practices" prior to signing this document. A copy of this Notice has been provided to me. The "Notice of Health Information Practices" describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations at Michigan Advanced Neurology Center. This "Notice of Health Information Practices" also describes my rights and Dr. Mridha's duties with respect to my protected health information.

Debasish Mridha, M.D. reserves the right to change the practices that are described in the "Notice of Health Information Practices." I may obtain a revised notice by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

The undersigned Patient or Authorized Representative acknowledges that he or she personally received a copy of the "Notice of Health Information Practices" on the date indicated below.

____ ________________
Signature of Patient or Authorized Representative Date

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Name of Patient (please print)

____
Relationship to Patient (if signed by Representative)

FOR OFFICE USE ONLY

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Office Representative Signature Date