

ALLERGY & ASTHMA CLINICS OF GEORGIA, P.C.

**PATIENT ACKNOWLEDGEMENT OF
NOTICE OF PRIVACY PRACTICES**

I have received a copy of the Notice of Privacy Practices of the Allergy & Asthma Clinics of Georgia, P. C. on the date indicated below.

I understand that if any changes are made to this Notice of Privacy Practices a revised copy of the Notice will be posted in the offices of the Allergy & Asthma Clinics of Georgia, P.C. within a reasonable time following the change.

I also understand that if I wish to receive additional copies of this Notice of Privacy Practices in the future or if I have any questions with regard to this Notice of Privacy Practices, I may contact:

T. Alan Moree
105 Spanish Court
Albany, Georgia 31707
(229) 438-7100 Phone
(229) 438-9382 Fax

Signature of Patient: _____

Print Name: _____

Date: _____