Endocrine Specialists of Georgia, LLC

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Francisco Puentes, MD, FACE

Patient Acknowledgment Form

Patient Name: _____ DOB:_____

I understand that the patient's health information is private and confidential. I understand that Endocrinology Specialists of Georgia, LLC works very hard to protect the patient's privacy and to preserve the confidentiality of patient's personal information.

I understand that Endocrinology Specialists of Georgia, LLC may use and disclose the patient's personal health information to help provide health care to the patient, to handle billing and payment issues and to take care of our health care operations. In general, there will be no other uses and disclosures of this information without my permission. Endocrinology Specialists of Georgia, LLC has a detailed document called the "Notice of Privacy Practices" that contains more information about the policies and practices protecting the patient's privacy and is attached for your review. I understand that I have the right to read the "Notice" before signing the Acknowledgment.

Within the "Notice" is contained a complete description of my Privacy/Confidentiality rights. These rights include, but are not limited to, access to my medical records, and restrictions on certain issues, receiving an accounting disclosure as required by law, and requesting communication by specified methods of communications.

Endocrinology Specialists of Georgia, LLC has established procedures with which to help them meet their obligations to patients. These procedures may include other signature requirements, written acknowledgment, and authorizations, charges for copies, etc.

My signature below indicates that I have been given the opportunity to review a current copy of Endocrinology Specialists of Georgia, LLC "Notice of Privacy Practices".

My signature below indicates that I have given Endocrinology Specialists of Georgia, LLC authorization to release my personal information to the following individuals in my absence:

Name: _____ Relationship to Patient: _____
Name: _____ Relationship to Patient: _____
Name: _____ Relationship to Patient: _____

_____ _____
Patient Signature Date