Acknowledgement of Receipt of Notice of Privacy Practices

This form will be retained in your medical record.

NOTICE TO PATIENT

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice.

Patient Name:_____ **Date of Birth:**_____

I acknowledge that I have **received and had the opportunity to review** the Notice of Privacy Practices on the date below on behalf of Complete Chiropractic.

I understand that the Notice describes the uses and disclosures of my protected health information by Complete Chiropractic and informs me of my rights with respect to my protected health information.

Patient's Signature or Legal Representative	*Printed Name of Patient or Legal Representative*
Today's Date	*If Legal Representative, Indicate Relationship*

Optional - Release of Information

I expressively give permission to Complete Chiropractic to release my Health information to

_____ (person able to receive information).

I understand that I have the right to revoke this authorization, in writing, at any time by the given notice of my revocation to the Privacy Officer, except to the extent that this action has been taken in reliance of this authorization. I understand that information disclosed as a result of this authorization may be subject to disclosure by the recipient and may no longer be protected by federal or state law. The covered entity may not condition treatment, payment, enrollment or eligibility on whether I sign this authorization except (1) if the information is required for safe and effective treatment (2) health care services are provided to me solely for the purpose of creating protected health information for the disclosure to a third party.

(Print Name of Patient)	(Date)	(DOB)

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(Signature of Patient)