Advanced CHIROPRACTIC

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Acknowledgement of Receipt of
Notice of Privacy Practices

NOTICE TO PATIENT

This form will be retained in your medical record.

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 Advanced Chiropractic.

I understand that the Notice describes the uses and disclosures of my protected health information by Advanced Chiropractic and informs me of my rights with respect to my protected health information. I also understand that I can find this entire form on www.AdvancedChiroClinic.com website.

_____ _____

Patient's Signature *or that of Legal Representative* ***Printed Name of Patient*** *or that of Legal Representative*

_____ _____

Today's Date ***If Legal Representative, Indicate Relationship***

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- ☐ The patient refused to sign.
- ☐ Due to an emergency situation it was not possible to obtain an acknowledgement
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ Other (please specify):_____

_____ _____

Employee's Name **Today's Date**

This form is based on current federal law, is subject to change based on changes in federal law, and the content may need to be modified to adhere to state law or subsequent guidance or advisories. Doctors are advised to consult with their state licensing Board or local counsel.