## 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.	
I acknowledge that I have <b>received and had the op</b> on the date below on behalf of Club West Ch	portunity to review the Notice of Privacy Practices iropractic
I understand that the Notice describes the uses and d  Club West Chiropractic and informs materials information.	isclosures of my protected health information by ne of my rights with respect to my protected health
Patient's Signature or that of Legal Representative	Printed Name of Patient or that of Legal Representative
Coday's Date	If Legal Representative, Indicate Relationship
FOR OFFICE	E USE ONLY
We have made every effort to obtain written acknowled patient but it could not be obtained because:  The patient refused to sign.  Due to an emergency situation it was not possil  Communications barriers prohibited obtaining to the Other (please specify):	ble to obtain an acknowledgement the acknowledgement
Employee Name	Today's Date

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This sample form does not constitute legal advice and is for educational purposes only. 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.