

Acknowledgement of Receipt of Notice of Privacy Practices

I have received a copy of Back to Action Chiropractic Center's Notice Of Privacy Practices that describes how my health information is used and shared. I understand that Back to Action has the right to change this notice at any time.

I may request a current copy be sent to me in the mail or ask for one at the time of my next appointment.

Signature of Patient or Legal Representative

Date

Printed Name of Patient, and relationship to patient if signed by legal representative

Dependants that are covered under this Receipt of Acknowledgement:

Printed Name of Patient, and relationship to patient if signed by legal representative & date

Printed Name of Patient, and relationship to patient if signed by legal representative & date

Printed Name of Patient, and relationship to patient if signed by legal representative & date

Printed Name of Patient, and relationship to patient if signed by legal representative & date