ACKNOWLEDGMENT OF RECEIPT OF NOTICE
PRESNICK CHIROPRACTIC

As required by the Privacy Regulations, I hereby acknowledge that I have received a current copy of *Presnick Chiropractic's* "NOTICE OF PRIVACY PRACTICES," revision date _____.

As required by the Privacy Regulations, _____ from *Presnick Chiropractic* has explained
Name of Staff Member
the " NOTICE OF PRIVACY PRACTICES" to my satisfaction.

As required by the Privacy Regulations, I am aware that *Presnick Chiropractic* has included a provision that it reserves the right to change the terms of its notice and to make the new notice provisions effective for all protected health information that it maintains.

Requests: {Optional}

☐ I wish to file a "Request for Restriction" of my Protected Health Information.

☐ I wish to file a "request for Alternative Communications" of my Protected Health Information.

☐ I wish to object to the following in the "Notice of Privacy Practices.

I understand that this office is not required to honor any changes to the "Notice of Privacy Practices."

_____ _____
Signature **Date**

_____
Print Name

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

This notice is effective as of _____/____/_____

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide *Presnick Chiropractic* with my authorization and consent to use and disclosed my protected my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

_____ _____ _____
Patient's Name (Print) Patients Signature Date

_____ _____
Authorized Facility Signature Date