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 CK Chiropractic Office, P.S..

I understand that the Notice describes the uses and disclosures of my protected health information by CK Chiropractic Office, P.S. and informs me of my rights with respect to my protected health information.

_____ _____

Patients Signature or that of Legal Representative *Printed Name of Patient or that of Legal Representative*

_____ _____

Today's Date *If Legal Representative: Indicate Relationship to Patient*

OFFICE USE ONLY

We have made every effort to obtain written acknowledgement 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.
____ Communication barriers prohibited obtaining the acknowledgement.
____ Other: _____

_____

_____ _____

Employee Name *Today's Date*

2851 NW Kitsap Place, Silverdale WA 98383 360-692-0181