

CHIROPRACTIC CENTER FOR HEALING

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

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

By way of my signature, I provide The Chiropractic Center for Healing with my authorization and consent to use and disclose 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)

Patient's Signature

Date

Authorized Facility Signature

Date