

Everybody's
CHIROPRACTIC CENTER

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**ACKNOWLEDGMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES**

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information, uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

Patient Name Printed

Patient Signature

Date

Guardian of a Minor Signature

Date