
Patient Acknowledgement



For use and/or disclosure of Protected Health Information (PHI) to carry out Treatment, Payment and Healthcare Operations

I, _____, hereby state that by signing this Consent I acknowledge and agree as follows:
(Print Name)

- 1) The Practice's Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out its health care operations. The Practice explained to me that the Privacy Notice would be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.
- 2) The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.
- 3) The Practice's "Notice of Privacy Practices" is also provided in the reception area display table and on the Practice's web site at www.UniversityChiroCA.com. I may also request a copy from this office at any time via US Mail.
- 4) This Notice of Privacy Practices also describes my rights and the duties of this office with respect to my protected health information.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

(Name of Individual - Printed)

(Date Signed)

(Signature of Individual)

(Signature of Legal Representative)

(Date Signed)

(Relationship)

(Witness - Office Personnel)

(Date Signed)