ACKNOWLEDMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand and have been provided with a copy of the NOTICE OF PRIVACY PRACTICES of *Rebarber Family Chiropractic,* detailing how my information may be used and disclosed as permitted under federal and state law.

I wish to have the following restrictions to the use or disclosure of my health information (*Rebarber Family Chiropractic* is not required to agree with these restrictions):

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I permit a copy of this authorization to be used to request payment of medical insurance benefits.

Patient Name: ____________________ **Signature**________________**Date:**____________

If not signed by the patient, indicate name and relationship (e.g., spouse)

Name:____________________ **Relationship:** ___________________

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OFFICE USE ONLY:

If patient refuses to sign, the employee giving the copy of the NOTICE will complete the following:

( ) Patient refused to sign this Acknowledgment.

Date:_______________________ Time:_________ Employee Name:_____________