

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE

ALLEN CHIROPRACTIC CARE, INC.

As required by the Privacy Regulations, I hereby acknowledge that I have received a current copy of Allen Chiropractic Care, Inc.'s "NOTICE OF PRIVACY PRACTICES," revision date _____

As required by the Privacy Regulations, _____ from _____

Name of Staff Member

Allen Chiropractic Care, Inc. has explained the "NOTICE OF PRIVACY PRACTICES" to my satisfaction.

As required by the Privacy Regulations, I am aware that Allen Chiropractic Care, Inc. has included a provision that it reserves the right to change the terms of its notice and to make the new notice provisions effective for all protected health information that it maintains.

Requests:

- I wish to file a "Request for Restriction" of my Protected Health Information.
- I wish to file a "Request for Alternative Communications" of my Protected Health Information.
- I wish to object to the following in the "Notice of Privacy Practices:"

In regards to your appointment, or scheduling issues:

- ___ yes ___ no May we call you at your home phone number
___ yes ___ no May we leave a message on your machine
___ yes ___ no May we leave a message with someone who answers the phone
___ yes ___ no May we call you at your place of employment

I understand that this office is not required to honor any changes to the "Notice of Privacy Practices."

Signature

Date

Print Name

(OFFICE USE ONLY)

Signed form received by: _____ Date: _____

Good faith effort to obtain receipt:
(Describe) _____

