Family Chiropractic & Nutrition
Acknowledgment and Consent of
Notice of Privacy Practices

I understand that **Family Chiropractic & Nutrition's** Notice of Privacy Practices, which explains how my medical information will be used and disclosed, is posted in the waiting room. I acknowledge that I have access to this information and I understand that I am entitled to receive a copy of this document if requested.

I authorize **Family Chiropractic & Nutrition** to use and disclose my medical information for the purpose of Treatment, Payment and Health Care Operations.

_____ _____

Signature of Patient or Authorized Representative Date

Patient Record of Disclosures

In general, The HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that communication of PHI be made by alternative means, such as sending correspondence to home or office, leaving messages on answering machines, and leaving lab or procedures results with spouse.

For appointment reminders, I wish to be contacted in the following manner:

_____ Text to:_____
_____ Email to:_____

For all other communication, I wish to be contacted in the following manner (check all that apply):

Home and cell telephone #_____

_____ Leave a message with detailed information
_____ Leave a message with callback number only
_____ Leave medical information with spouse.

Written communication

_____ Mail to my home address
_____ Fax to this number _____

This consent will remain in effect unless otherwise revoked in writing.

_____ _____

Signature of Patient or Authorized Representative Date