ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

By checking the lines below I authorize being contacted for appointment reminders by: Email____ at email address_____
Telephone numbers____ at_____
By voice mail____
By text message____

By checking the line below I authorize receiving free newsletters, blogs, workshop announcements, and other important communications about the practice by:
Email____ at email address_____

By checking the lines below I authorize the doctor to send information to me about products that may benefit my health or condition such as nutritional supplements, orthopedic products, or other third-party products or services by:
Email____ at email address_____

_____ _____
Patient Name (please print) Date

_____ _____
Signature of Patient, Parent, Guardian or Patient's legal representative

Print Name of Parent, Guardian or Patient's Legal Representative

THIS FORM WILL BE PLACED IN THE PATIENT'S CHART AND MAINTAINED FOR SIX YEARS.

List below the names and relationship of people to whom you authorize the Practice to release Protected Health Information (PHI).

_____ _____

_____ _____