ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY

I acknowledge that as a patient I have received, reviewed and understand the Cooper Chiropractic Notice of Privacy Practices.

Patient's Printed Name ____
(Please Print)

I understand that I have the right to:

- Refuse to sign this authorization.
- Receive a signed copy of this authorization.

I have read, reviewed and been offered to receive a copy of the Practice's Notice of Cooper Chiropractic and understand that my protected health information may be used by the office as described in the notice.

Signature of Patient ____________________________________ Date: _____________________
(or Personal Representative)

Name of personal Representative _______________________________________
Relation to patient _______________________________________

Please note the Personal Representative is the patient's decision maker if the patient cannot act for himself or herself. It can be the parent, legal guardian, health care surrogate, or other named individual.

Consent of Release of Protected Health Information

I acknowledge and give permission to _____________________________________ to have access to the following:(This would be the person you allow to have access to your files. You do not have to list anyone.)

Check items you give permission to this individual for
_____ Pick up in the office paperwork or medical records
_____ Release information about test or radiology results results
_____ Release information about my account status
_____ Release information about appointments, missed visits, coordination of care with other physicians, lab results, accounts receivable, educational materials or any other items related to the continuation, coordination or item related to your healthcare treatment in the office.

Signature of Patient ____________________________________ Date: _____________________
(or Personal Representative)

Witnessed by staff ____________________________ _______ Date: _____________________