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## Acknowledgement of Receipt of Notice of Privacy Practices

*This form will be retained in your medical record.*

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### NOTICE TO PATIENT

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We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice.

**Patient Name:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

I acknowledge that I have **received and had the opportunity to review** the Notice of Privacy Practices on the date below on behalf of TCR Chiropractic.

I understand that the Notice describes the uses and disclosures of my protected health information by TCR Chiropractic and informs me of my rights with respect to my protected health information.

\_\_\_\_\_  
*Patient's Signature or that of Legal Representative*

\_\_\_\_\_  
*Printed Name of Patient or that of Legal Representative*

\_\_\_\_\_  
*Today's Date*

\_\_\_\_\_  
*If Legal Representative, Indicate Relationship*