ACKNOWLEDGEMENT 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.**
- **I understand the Notice of Privacy Practices.**
- **I understand that this form will be placed in my patient chart and will be maintained for six years, or until it is replaced.**

_______________________________________ _______________________

Patient Name (PRINT) **Date**

____

Parent, Guardian, or Patient's Legal Representative

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Signature

Please list below the names and relationships of people to whom you authorize Northcreek Chiropractic Clinic to release your protected health information.

Name	Relationship
1.	
2.	
3.	