Harrison Chiropractic Center

Acknowledge of Receipt of Notice of Privacy practices

I understand that by signing this form I acknowledge that I have received, reviewed, understand and agree to the Notice of Privacy Practices of Harrison Chiropractic Center. The Notice describes the practice policies and procedures regarding the use and disclosure of any of my protected health information created, received or maintained by the practice in accordance with HIPPA guidelines.

Print Name:

_____

Signature:

_____

Signature if Parent or Guardian if under 18 years of age or unable to sign:

_____

Date:

_____