ACCESS TO HEALTH CHIROPRACTIC CENTER
57 Lafayette Street
Norwich, CT 06360

Michael W. Allard, DC.
Clinic Director
Lori D. Raymond, ND.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY AND OR OPTION OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I:

☐ Was provided a copy of the Notice of Privacy Practices

☐ Was provided a copy of the Notice of Privacy Practices and 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.

_____
Patient Name (Please print)

_____ _____
Signature Date

_____
Parent/Guardian or legal representative

_____ _____
Signature Date

_____ _____
Witness Date