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

Michael W. Allard, DC.
Clinic Director
Kathleen Cannon, 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

HIPAA AUTHORIZATION TO DISCUSS YOUR MEDICAL INFORMATION Indicated below are names of any Person(s) to whom I would like Access to Health or Dr.Cannon to allow disclosure of Protected Health Information (PHI). I understand that I am not required to list anyone and I may change this list at any time in writing.

Name	Relationship	Phone number