ACCESS TO HEALTH CHIROPRACTIC CENTER

68 Salem Turnpike Norwich, CT 06360

Michael W. Allard, DC.

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 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_____

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