

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have had the opportunity to review a copy of Fusion Chiropractic, Inc. Notice of Privacy Practices (“Notice”).

I understand that I am responsible to read this Notice and notify Fusion Chiropractic, Inc, in writing, of any request for restrictions in the use or disclosure of my protected health information (“PHI”).

I understand Fusion Chiropractic, Inc. has the right to revise this Notice at any time and will post a copy of the current Notice in the office in a visible location at all times and on their website at www.Fusion-Chiro.com.

Fusion Chiropractic, Inc will provide me with a copy of its most recent Notice upon my request.

Patient Name: _____

Date of Birth: _____

Patient Signature: _____

Name(s) of others authorized to discuss or receive my PHI:
