MG Dodge Chiropractic,PC
Michelle Gaebel Dodge, DC

Acknowledgement of Receipt of
Notice of Privacy Practices

This form will be retained in your medical record

NOTICE TO PATIENT

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the notice

Patient Name:_____ Date of Birth: __/___/_____

I acknowledge that I have received and had the opportunity to review the Notice of Privacy Practices on the date below on behalf of MG Dodge Chiropractic PC

I understand that the notice describes the users and disclosures of my protected health information by MG Dodge Chiropractic ,PC and informs me of my rights with respect to my protected health information.

_____ _____

Patient's Signature
Or that of legal Representative

Printed Name of Patient
Or that of legal Representative

____/____/_____ _____

Today's Date

If legal Representative, Indicate Relationship

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- ❏ The patient refused to sign
- ❏ Due to an emergency situation it was not possible to obtain an acknowledgement
- ❏ Communications barriers prohibited obtaining the acknowledgment

❑ Other (please specify):_____