ACKNOWLEDGMENT OF RECEIPT

OF

NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand this form will be placed in my patient chart and maintained for six years.

By checking **one** of the lines below, I authorize being contacted for appointment reminders by:

_____ Text at cell phone number _____ @ Network:_____
Or

_____ Email at email address: _____
Or

_____ Voice Mail at phone number _____

_____ By checking this line I authorize receiving free newsletters, blogs, workshop announcements, and other important communications about the practice by email at email address_____

_____ By checking this line I authorize the doctor to send information to me about products that may benefit my health or condition such as nutritional supplements, orthopedic products, or other third-party products or services by email at email address_____

_____ _____
Patient Name (please print) Date

_____ _____
Signature of Patient, Parent, Guardian, or Patient's legal representative

Print Name of Parent, Guardian, or Patient's legal representative

THIS FORM WILL BE PLACED IN THE PATIENT'S CHART AND MAINTAINED FOR SIX YEARS.

List below the names and relationship of people to whom you authorize the Practice to release Protected Health Information (PHI).

_____ _____

_____ _____