Doinidis Chiropractic
Life Center
The Natural Way To Health

ACKNOWLEDGEMENT OF RECEIPT OF OFFICE PRIVACY POLICY

I acknowledge that **Doinidis Chiropractic's** Notice of Privacy Practices has been provided to me. I understand that I have a right to review **Doinidis Chiropractic's** Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of **Doinidis Chiropractic.** It describes my rights as they concern the limited use of health information, including my demographic information, collected from me and created or received by my physician. The Notice of Privacy Practices for **Doinidis Chiropractic** is also provided on request at the main administration desk of this practice and may soon be on **Doinidis Chiropractic's** website.

Doinidis Chiropractic reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____ _____

Signature of Patient or Personal Representative Date

_____

Name of Patient or Personal Representative

_____

Description of Personal Representative's Authority