Casa View Chiropractic Clinic, Inc.

Patient Acknowledgment and Receipt of
Notice of Privacy Practices Pursuant to HIPAA and
Consent for Use of Health Information.

Name_____ Date_____
Print Patient Name

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant to HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersigned does hereby consent to the used of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State and Federal Law.

Dated this _____ day of _____, 20____

By _____
PATIENT'S SIGNATURE

If patient is a minor or under a guardianship order as defined by State Law:

By _____
SIGNATURE OF PARENT / GUARDIAN (circle one)

FORM MUST BE **SIGNED IN OFFICE** ONCE THE PATIENT RECIEVES THE OFFICE PRIVACY PRACTICES.