BAZIL CHIROPRACTIC HEALTH CENTER
18800 Main Street, Suite 207
Huntington Beach, CA 92648
(714) 375-5864

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgment

I, _____, have received a copy of this office's
Patient/Parent/Guardian Name
Notice of Privacy Practices explaining:

- How this office will use and disclose my protected health information.
- My privacy rights with respect to my protected health information.
- This office's obligation concerning the use and disclosure of my protected health information.

I understand that the *Notice of Privacy Practices* may be revised from time to time and that I am entitled to receive a copy of any revised *Notice of Privacy Practices* upon request.

I also understand that if I have any questions or complaints, I may contact the U.S. Department of Health and Human Services.

Signature: _____ Date: _____/_____/_____

Name: _____

Relationship to Patient: _____

FOR OFFICE USE ONLY

A good-faith attempt to obtain written acknowledgment of receipt of our *Notice of Privacy Practices* was made, but acknowledgment could not be obtained because:

- Patient refused to sign (Date of refusal _____/_____/_____)
- Communication barriers prohibited obtaining an acknowledgement.
- An emergency situation prevented us from obtaining an acknowledgement
- Other _____

Attempt was made by _____ Date: ___/_____/_____