PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF HIPAA

I hereby acknowledge receipt of the Notice of Privacy Practices for **All Care Chiropractic And Wellness Center** regarding my health information. I have been informed and understand the manner in which my health information shall be maintained, utilized and disclosed by Clinic and my respective rights contained there in. I also understand that the Notice furnished to me is subject to change at any time. I am aware that I may obtain a current copy of this Notice at any time by contacting **Jason Koch, DC at 412-751-3333 or 724-591-8288.**

My signature herein below constitutes full acknowledgement that I have furnished a copy of the Notice of Privacy Practices for **All Care Chiropractic And Wellness Center.**

_____

Patient Signature Date

_____

Patient's Legal Representative Date
if required

If signed by patient's legal representative,
please state representative's relationship to patient: _____