

**NOTICE OF PATIENT PRIVACY
Acknowledgement of Receipt**

Date _____

We are committed to preserving the privacy of your personal health information. In fact, we are required by law to protect the privacy of your medical information and to provide you with notice describing:

**HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND
DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION.**

We may require your written consent before we use and disclose to others your medical information for purposes of providing or arranging for your health care, the payment for or reimbursement of the care that we provide to you, and the related administrative activities supporting your treatment.

As our patient, you have important rights relating to inspecting and copying your medical information that we maintain, amending or correcting that information, obtaining an accounting of our disclosures of your medical information, requesting that we communicate with you confidentially, requesting that we restrict certain uses and disclosures of your health information, and complaining if you think your rights have been violated.

We have available a detailed *Notice of Privacy Practices* which fully explains your rights and our obligations under the law. We may revise our notice from time to time. The effective date at the top right hand side of this page indicates the most current notice in effect.

You have the right to receive a copy of our most recent notice in effect. If you have not yet received a copy of our current notice, please ask at the front desk and we will provide you with a copy.

If you have any questions, concerns or complaints about this notice or your medical information, please contact Advanced Chiropractic Group's office at (805) 681-7322.

I acknowledge that I have been informed of the *Notice of Privacy Practices of Advanced Chiropractic Group*.

Signature _____ Date _____