RICHMOND CHIROPRACTIC SOLUTIONS

Acknowledgement of Receipt of Notice of Privacy Practices*

This form will be retained in your medical record. Your medical records will be retained for six years after you last visit and then either transferred to you or destroyed by shredding or incineration.

NOTICE TO PATIENT

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice.

Patient Name:_____ **Date of Birth:**_____

I acknowledge that I have **received and had the opportunity to review** the Notice of Privacy Practices on the date below on behalf of **RICHMOND CHIROPRACTIC SOLUTIONS**.

I understand that the Notice describes the uses and disclosures of my protected health information by **RICHMOND CHIROPRACTIC SOLUTIONS** and informs me of my rights with respect to my protected health information.

Patient's Signature or that of Legal Representative	Printed Name of Patient or that of Legal Representative
Today's Date	If Legal Representative, Indicate Relationship

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- ☐ The patient refused to sign.
- ☐ Due to an emergency situation it was not possible to obtain an acknowledgement
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ Other (please specify):_____

Employee Name	*Today's Date*

*As located at www.richmondchiropracticsolutions.com/newpatients/officeforms