



AMADOR VALLEY CHIROPRACTIC HEALTH CENTER

ACKNOWLEDGEMENT OF REVIEW OF PRIVACY NOTICE

I acknowledge that I received a copy of the Practice's Privacy (HIPAA) notice that has an effective date of April 14, 2003.

\_\_\_\_\_  
Patient Name (Print)

\_\_\_\_\_  
Signature

Date signed: \_\_\_\_\_

If you wish your information to be disclosed/discussed with, i.e. spouse, parent, relative, caretaker, secretary/assistant. Such information may include but not be limited to scheduling of appointments, discussing your condition/treatment with the doctor, account information, health plan benefits, etc. Please list name(s) below.

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

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We would also like to have your cell phone number and email address:

Cell: \_\_\_\_\_

Email: \_\_\_\_\_

Thank you.