Gilroy Chiropractic Center
7888 Wren Ave, Ste B-123
Gilroy, CA 95020
(408)848-3666

HIPAA Privacy Practices Consent

Name of Patient: _____

Date of Birth: _____

I acknowledge that I have read and understand the Gilroy Chiropractic Center HIPAA Notice of Privacy Practices and have received a written copy if requested. If I am not the patient, I represent that I am authorized by law to act on the patient's behalf.

_____ _____
Signature **Date**

If not signed by patient, indicate authority to act for patient: _____

FOR OFFICE USE ONLY

COMPLETE IF NO ACKNOWLEDGEMENT CAN BE OBTAINED

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained from the patient or patient's authorized representative because:

_____ Individual refused to sign
_____ Other (please describe) _____

_____ _____
Signature Date