Cumberland Valley Chiropractic & Wellness Acknowledgement of Receipt of Notice of Privacy Practices

Reporting of test/imaging results, and medical information

Messages may be left of my answering machine _____Yes _____No

My results and medical information may be shared with

Name_____

Relationship_____ Phone_____

Name_____

Relationship_____ Phone_____

_____ Please **do not** release my information to anyone.

I am aware of the office's Notice of Privacy Practices. I am the patient, parent, legal guardian, or have Power of Attorney for this patient and am signing on their behalf. I authorize this office to use facsimile as a means of rapid communication with other physician's offices, pharmacies, laboratories and/or insurance companies for information that is pertinent to my care.

I have read and understand the above statements.

_____ _____

Please print patient's full name Date of birth

_____ _____

Signature of patient, parent, legal guardian or Power of Attorney Date