HAN ZARYK CHIROPRACTIC
NEUROLOGY GROUP

ACKNOWLEDGMENT OF RECEIPT OF HIPAA PRIVACY NOTICE

I, _____ , understand that I have the right to receive a copy of this office's Notice of Privacy Practices upon request. I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

Conduct, plan and direct my treatment and follow-up a month the health care providers who may be directly and indirectly involved in providing my treatment.

Obtain payment from third party payers.

Conduct normal health care operations such as quality assessments and accreditation.

_____

Patient

_____

Signature

_____

Date

Dr. Christine Hanczaryk
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