Acknowledgment Of Receipt Of Notice Of Privacy Practices

I acknowledge that I was provided a copy of the Notice of Privacy Practices of Dr. John P. Baskett, D.C, P.A, DBA Putnam County Chiropractic Clinic and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

__________________________ ______________

Patient Name (please print) Date

____

Parent, Guardian, or Patient’s Legal Representative

____

Signature

THIS FORM WILL BE PLACED IN THE PATIENT’S CHART AND MAINTAINED FOR SIX YEARS.

List below the names and relationships of people to whom you authorize the Practice to release PHI.

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