Privacy Practices – Patient Reception Form

I have received or reviewed the privacy practice notice for Abundant Life Chiropractic, and understand the situations in which this practice may need to utilize or release my medical records. I also understand that I agreed to the use of those records when I initially applied for care at this office (my Application For Care) on my first visit, whenever that may have occurred.

I understand that this office will properly maintain my records, and will use all due means to protect my privacy as outlined in the privacy practices statement.

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Patient Signature Date

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Print the Patient Name