

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

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

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.

Signature	Date
-----------	------

Signature of parent or legal guardian, if patient is under 18, or Power of Attorney