Wunderlich Chiropractic Clinic, P.A.

Dr. Chance Wunderlich

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ACKNOWLEDGMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the *Notice of Privacy Practices* 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.

Communications:

Who do you authorize our office to communicate your healthcare information with?

Spouse: _____
Children: _____
Others: _____

Authorizations:

By checking the lines below I authorize being contacted for practice reminders, birthday greetings or promotions by:

- **Mail** _____
- **Email**_____ at email address _____.
- **Telephone numbers**_____ preferred telephone number _____.
- By **voice mail** _____.
- By **text message** _____.

Our office will only use this information as authorized by you. We do not share this information without your consent.

_____ _____
Patient Name (please print) Date

_____
Name of Parent, Guardian or Patient's legal representative