FAMILY CHIROPRACTIC OF MERRIMACK AND WELLNESS CENTER LLC

36 Baboosic Lake Road Merrimack NH 03103
603-262-9200

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES HIPPA (Health Insurance Privacy and Portability Act.)

I have received a copy of the HIPPA notice for this office's privacy practices.

Printed Name:____

Signature:____ **DATE:** ______________

Should you be under 18years of age a Parent/ or Legal Guardian must sign this form for your Hippa Recognition.

Printed Name of Minor:____

Printed Name of Person Signing & Relationship:_____________________________________

Signature of Parent or Legal Guardian:__________________________________**Date:**__________

For those of legal adult age of 18 or over: I hereby give my permission to discuss any and all aspects of my chiropractic treatment to the following individuals listed below, including but not limited to changes in my schedule, payments made by others on my behalf, insurance or changes in insurance, or changes with my care plan in the office, as well as having them obtain important information should I not be available.

- Spouse: ____
- Significant Other:____
- Mother: ____
- Father: ____
- Specific Other:____

*Should you want your records transferred to another health care professional please list the office with as much information as you can. If throughout your care you would like your records shared you will be asked to sign another release for that specific office as well.

Name of
Office:____
_

Doctor or Practitioners
Name:____

Phone
Number:____
___