PRIVACY NOTICE ACKNOWLEDGEMENT

We are very concerned with protecting your privacy, especially in matters that concern your personal health information. In accordance with the *Health Insurance Portability and Accountability Act of 1996* (HIPPA), we are required to supply you with a copy of our privacy policies and procedures. We encourage you to read this document carefully for it outlines the use and limitations of the disclosure of your health information and your rights as a patient. If you ever have questions or concerns regarding the use or dissemination of your personal health information, we would be happy to address them.

I acknowledge that I have received a copy of Dr. O'Malley's *Notice of Privacy Practices for Protected Health Information.*

_____ _____

Patient Name Printed Date

_____ _____

Patient Signature Authorized Provider Rep.

OR

_____

Parent or Personal Representative Printed

_____

Parent or Personal Rep. Signature

HEALTH AND MEDICAL INFORMATION RELEASE

I, _____, also give Drs. O'Malley and their staff permission to share private and medical information with my **medical doctor,** _____, as well as his or her staff, employees and associates. Also, my doctor, as well as his or her staff, employees and associates have permission to share information **relevant to my chiropractic treatment** with Drs. O'Malley and their staff.

Signature:_____ Date:_____