Ybor City
CHIROPRACTIC

1623 East 4th Avenue
Tampa, Florida 33605
813-248-2900

Acknowledgement 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 (6) years.

Patient Name: ______________________________ Date: ______________

Patient Signature: ______________________________

Witness Signature: ______________________________

This form will be placed in the patient's chart and maintained for six (6) years.