Notice of Privacy Practices Acknowledgement

I understand that under the Health Insurance Portability and Accountability Act **(HIPAA)**, I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

PRINT PATIENT NAME: _____

PATIENT SIGNATURE: _____

DATE:_____ /_____ /_____

Office Use Only

We have made the following attempt to obtain the patients' signature acknowledging receipt of the Notice of Privacy Practices:

Date:_____ **Attempt:**_____

Staff Name: _____

Holladay Chiropractic
3424 South 2300 East
Salt Lake City, UT 84109
(801) 486-9201