CHIROPRACTIC
HEALING CENTER
OF NEW JERSEY

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Acknowledgement of Receipt of our Privacy Notice

I have been presented with a copy of the **Notice of Privacy Policies** of the practice of Chiropractic Healing Center of NJ detailing how my information may be used and disclosed as permitted under federal and state law. In general, HIPAA privacy rule gives me the right to request a restriction on use and disclose of my PHI (Protected Health Information). I understand the contents of the Notice, and I request the following restriction(s) concerning the use of my person medical information:

_____

_____

Further, I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to medical assignment of benefits apply.
I understand that as part of this organization's treatment, payment, or healthcare operations, it may be necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosure via fax.

Signed: _____ **Date:** _____

I specifically authorize disclosure of my protected health information to

_____ my _____
(Name) (Relationship)

Description of the information to be used or disclosed (check all that apply)

( ) Condition
( ) Professional Service
( ) Medications
( ) Test Results

I understand that this notice will remain in effect and that I have the right to revoke this authorization in writing, except to the extent that action has been taken in reliance on this authorization or, if applicable during a contestability period. In order for the revocation to be effective, New Jersey Total Health Center must receive the revocation in writing.

Signed: _____ **Date:** _____

If not signed by patient, please indicate relationship to patient (e.g., spouse)
Relationship: **Witness by:**

INTERNAL USE ONLY:
If patient or patient's representative refuses to sign acknowledgement of receipt of notice, please document the date and time the notice was presented to patient and sign below.
By: _____ Presented on: _____