Allison J. Scharf, DC

ACKNOWLDEGEMENT AND CONSENT

By signing below, I acknowledge that I have been provided a copy of my chiropractor's Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by this office, and how I may obtain access to and control this information. I also acknowledge and understand that I may request copies of separate notices explaining special privacy protections that apply to HIV/AIDS related information, and generic information. Finally, by signing below, I consent to the use and disclosure of my health information to treat me and arrange for my chiropractic care, to seek and receive payment for services given to me, and for the business operation of the office, its physicians and staff.

_____

Signature of patient or patient's personal representative

_____

Print name of patient or patient's personal representative

_____

Description of personal representative's authority

_____

Date

If you have any questions about this notice of would like further information, please contact the office manager.

For office use only: If the patient does not sign this acknowledgement and consent form, record here the good faith efforts made to obtain this acknowledgement and consent.