

PURCELL CHIROPRACTIC
1205 N. Green Ave.
Purcell, OK 73080
PH: (405) 527-3323 FAX: (405) 527-4595
Dr. Aaron Perkins

**Patient Acknowledgement and Receipt of
Notice of Privacy Practices Pursuant to HIPAA and
Consent for Use of Health Information**

Name: _____ **Date:** _____

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant to HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersigned does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State Law and Federal Law.

Dated this _____ day of _____, 20____

By _____
Patient's Signature

If patient is a minor or under a guardianship order as defined by State Law:

By _____
Signature of Parent/Guardian (circle one)

