ADVANCED CHIROPRACTIC SPECIALISTS

Privacy Practices Acknowledgement

I have received the Notice of Privacy Practices and have been provided an opportunity to review it. ______ (initial)

I further give consent to Advanced Chiropractic Specialists to release information concerning my medical condition to the following person(s):

Printed Name of Individual(s)	Relationship
________________________________	____________________
________________________________	____________________
________________________________	____________________
________________________________	____________________
________________________________	____________________

Patient Name ______________________________ Birthdate ___________________

Signature ____

Date _______________________