Patient Name ______________________________

FullCircle Acupuncture HealthCentre

Acknowledgement of Receipt of the Notice of Privacy Practices

I have received the NOTICE OF PATIENT PRIVACY PRACTICES which describes how my protected health care information may be used and disclosed to carry out treatment, payment of services, health care operations, and other purposes as provided by law. This notice also describes my patient rights to have my records protected.

The center reserves the right to change the privacy practices described in the NOTICE OF PATIENT PRIVACY PRACTICES. All changes will be posted in the clinic area. I understand that I may request a copy of this notice at any time and discuss its contents with my acupuncturist.

Signature Patient or Guardian_________________________ Date ___/___/_____

Print Name____