ACKNOWLEGMENT *of* RECIEPT *of the*

NOTICE of PRIVACY PRACTICES *of*

Strand Spine Institute

herein after referred to as *the Clinic*.

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that these privacy practices will be followed by ***the Clinic*** to ensure the privacy of my personal health information. I understand that this form will be placed in my patient chart and maintained for six years.

_____ _____

Patient Name (*please print*) **Date**

_____

Signature of Patient, Parent, Legal Guardian or Patient's Legal Representative

Please list below the names and your relationship of people to whom you authorize *the Clinic* to release your private health information:

Print Name	**Relationship**

This form will be placed in the patient's chart and maintained for six years.