PRIVACY PRACTICES

PATIENT RECEPTION FORM

The Offices of Dr. Jack R. Giangiulio, D.C., a chiropractic healthcare facility, have made available to me their office's HIPPA privacy notices (4 pages).

I agree that I have received and have been given the opportunity to reviewed the privacy practice notice prior to my initial care at the facility, and understand the situations in which the Offices of Dr. Jack R. Giangiulio, D.C. may need to utilize or release my medical records. I also fully understand and fully agree that the Offices of Dr. Jack R. Giangiulio, D.C. may utilize and care for my records as outlined in their office's HIPPA privacy notice.

I understand that this office will properly maintain my records, and will use all due means to protect my privacy as stated in the HIPPA privacy notice.

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Patient Signature / Guardian Signature Date

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Print the Patient's Name

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Print the Guardian's Name