ACKNOWLEDGEMENT OF RECEIPT OF THE NOTICE OF PRIVACY PRACTICES OF KSCWC, LLC

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 ready them, and understand the Notice of Privacy Practices. I understand that these privacy practices will be followed by Keystone Spinal Care & Wellness Center, LLC to ensure the privacy of my personal health information. I understand that this will be placed in my member 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 names of relationships to people to whom you authorize KSCWC to release your private health information.

Print Name **Relationship**

_____

_____

_____

_____

_____

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