David A. Czerminski, D.C.
Glen Rock Chiropractic Center

Acknowledgement of receipt of Notice of Privacy Practices Form

I, _____ acknowledge that I have
(Name of Patient)
received or reviewed the privacy practice notice for *Glen Rock Chiropractic Center,* and understand the situations in which this practice may need to utilize or release my medical records. I also understand that I agreed to the use of those records when I initially applied for care at this office (my Application for Care; Case History form) on my first visit, whenever that my have occurred.

I understand that this office will properly maintain my records, and will use all due means to protect my privacy as outlined in this privacy practices statement.

_____ _____
Patient Signature Date

_____
Relationship to Patient

885 Lincoln Avenue Glen Rock, New Jersey 07452
Phone: (201) 670-9093 Fax: (201) 670-7351