

PATIENT NAME \_\_\_\_\_

I acknowledge that I have received a copy of Reaves Chiropractic Notice of Privacy Practices regarding patient privacy rights.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**CONSENT FOR ADDITIONAL PHI DISCLOSURES**

Reaves Chiropractic may disclose information concerning my diagnoses or treatment to the following persons or offices:

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date