HIPAA NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT & CONSENT

King Osteopathic Medicine & Medical Acuouncture, PLLC.
32 S Morton Ave, Morton, PA

ACKNOWLEDGEMENT FORM

I have received the HIPAA Notice of Privacy Practices and I have been provided an opportunity to review it.

Date: _____ Patient Date of Birth: _____

Patient Name:_____

Patient Signature: _____

Name of Parent / Guardian if signing for Patient: _____

Parent / Guardian Signature: _____