HIPAA NOTICE OF PRIVACY PRACTICES FORM

ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES (rev. 2/2026)

Patient Name: _____

Date of Birth: _____

I acknowledge that I have been made aware and that I have been offered the opportunity to review the **Notice of Privacy Practices** (located in the clinic lobby) from Morris Family Chiropractic, which explains how my medical information will be used and disclosed, and how I can get access to this information. I also acknowledge that I am entitled to a copy of this Notice of Privacy Practices upon request. I understand that the Notice of Privacy Practices may be revised periodically and that I can request a copy of any revisions by contacting the practice. I also understand that if I have any questions regarding the Notice of Privacy Practices, I can contact the Privacy Officer at 850-892-4636 or in writing at PO BOX 1130, DeFuniak Springs, FL 32435. https://www.hhs.gov/hipaa/for-individuals/notice-privacy-practices/index.html

By signing below, I acknowledge that I have received and reviewed a copy of this notice. This notice will be kept in my record for up to six years.

I also give Morris Family Chiropractic permission to:

Please initial:

- Leave a message on my voicemail.
  _____ Yes _____ No
- Confirm appointments by leaving messages or speaking with family.
  _____ Yes _____ No
- Text/Email important appointment info and/or to confirm.
  _____ Yes _____ No

The practice may speak with regarding PHI (Personal Health Information) and my care:

PERSON OR DOCTOR(S):	**RELATIONSHIP TO PATIENT:**
_____	_____
_____	_____
_____	_____

_____ _____
Patient Signature Date

_____ _____
Parent/Guardian/Legal **Representative** Signature Relationship to Patient