LOGAN UNIVERSITY
HEALTH CENTERS

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have been given a copy of the Logan University Chiropractic Health Center (Logan) *Notice of Privacy Practices ("Notice*"), which describes how my health information is used and shared. I understand that Logan has the right to change this *Notice* at any time. I may obtain a current copy by requesting one or by visiting the Logan University web site at www.logan.edu.

My signature below acknowledges that I have been provided with a copy of Logan's Notice of Privacy Practices:

_____ _____

Signature of Patient or Personal Representative *Date*

_____

Print Name

_____

Personal Representative's Title or Relationship to Patient

For Logan University Staff Only: *Complete this section if you are unable to obtain a signature***.**

If the patient or personal representative is unable or unwilling to sign this *Acknowledgement*, or the *Acknowledgement* is not signed for any other reason, state the reason:

_____

_____

Describe the steps taken to obtain the patient's (or personal representative's) signature on the *Acknowledgement:*

_____

_____

Completed by:

_____ _____

Signature of Logan University Representative Date

_____

Print Name

Updated: 12/8/17