



Memphis Chiropractic Neurology

Notice of HIPAA Privacy Practices

My signature below acknowledges that I have read and understood the Privacy Practices of Memphis Chiropractic Neurology. It also acknowledges that I received a copy of the Notice of Privacy Practices.

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

I hereby authorize Memphis Chiropractic Neurology to release information regarding my protected Health information to include account status, treatment, test results, and scheduled appointments to the person(s) listed below:

\_\_\_\_\_

\_\_\_\_\_  
Signature