Miller Chiropractic Clinic

Dr. William A. Miller, D.C.P.A.
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HIPAA PRIVACY STATEMENT ACKNOWLEGEMENT

By Signing below I agree to the following:

1. I was given the opportunity to read the HIPAA Privacy Statement.
2. I was offered a copy of the HIPAA Privacy Statement to take with me.

DESIGNATION OF COMMUNICATION

If you would like to designate a family member or caretaker with whom we may communicate regarding your health information, please list his/her name and relationship: _____

HOW WE MAY CONTACT YOU REGARDING APPOINTMENTS

1. May we contact you at work?	Yes____	No____
2. May we leave a message with your office?	Yes____	No____
3. May we call you at home?	Yes____	No____
4. May we leave a message at home?	Yes____	No____

_____
Print Name

_____ _____
Signature Date