ACKNOWLEDGMENT OF RECEIPT OF PRIVACY POLICY

I have been presented with a copy of Raymond A. Semente DC, PC's notice of privacy policies detailing how my information may be used and disclosed as permitted under federal law. I understand the contents of the nice and I request the following restriction(s) concerning the use of my personal medical information:

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I permit a copy of this authorization to be used in place of the original and request payment of my medical insurance benefits either to myself or to the party who accepts my assignment. Regulations pertaining to medical assignment of benefits apply.

Signed: ______________________ Date:________________

If not signed by patient, indicate relationship to patient (ex: spouse)

Relationship: __________________ Witnessed by: __________

Internal Use Only:
If patient's representative refuses to sign acknowledgment of receipt of notice, please document the dates and times the notice was presented to the patient and sign below.

Presented on (date and time): __________________

By (name and title): __________________________