

JACK P. ZANGARA, DC

Acknowledgement of Receipt Privacy Policy

I have been presented with a copy of Jack P. Zangara, D.C.'s NOTICE OF PRIVACY POLICIES, detailing how my information will be used and disclosed as permitted under Federal and State law. I understand and the contents of the Notice, and I request the following restriction(s) concerning the use of my personal medical information:

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

Patient's Name: _____ ***Date:*** _____

Signature of Patient or Legal Representative: _____

Relationship to Patient: _____ ***Witness:*** _____

For Internal Use:

If patient or patient's legal representative refuses to sign acknowledgement of receipt of notice, please document date and time notice was presented to patient or patient's legal representative and sign below.

Date and Time presented: _____

Presented by: _____

(Revised 08/2023)