Pauline M. Canelias, D.C.

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HIPAA policy acknowledgement

By signing below, I acknowledge that I have been provided with a copy of our pledge to privacy practices and records access, and have therefore been advised of how health information may be used and disclosed by the above-captioned facility, and how I may obtain access to and control this information.

Signature of patient or personal representative Date

Print name of patient or personal representative

Description of personal representative's authority (if applicable)

I am paying for services upfront and in full, and choose to restrict disclosure of my Protected Health Information from my health plan:

Signature Date