

**Warren Chiropractic / David W. Schlingloff, DC**

Acknowledgement of Privacy Practice Notice  
And  
Designation of Disclosure

I. Acknowledgement of Privacy Practice Notice

I have received a copy of the Warren Chiropractic Notice of Privacy Practices.

\_\_\_\_\_  
Patient's Name      Date of Birth      Signature of Patient/ Parent/ Guardian

II. Designation of Certain Relatives, Close Friends and other Caregivers.

I agree that Dr. David Schlingloff may disclose certain personal health information to a family member, close friend or other caregiver because such person is involved with my health care or payment relating to my health care. In that case Dr. David Schlingloff will **disclose only information that is directly relevant to the person's involvement with my health care or payment relating to my health care.**

I designate the following persons listed below as persons involved with my health care or payment relating to my health care for the purpose of Dr. David Schlingloff making the limited disclosures described above. I understand that I am not required to list anyone. I also understand that I may change this list at any time in writing.

Print Name: \_\_\_\_\_ Phone # \_\_\_\_\_

Print Name: \_\_\_\_\_ Phone# \_\_\_\_\_

Print Name: \_\_\_\_\_ Phone# \_\_\_\_\_

\_\_\_\_\_  
Signature of Patient/ Parent / Guardian

\_\_\_\_\_  
Date