

Dr. Jana Joshu Grimm, DC
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Acknowledgement of Receipt of Notice of Privacy Practice

I certify that I have read or reviewed **Dr. Jana Joshu Grimm's** Notice of Privacy Practices as displayed in the office and/or at <http://www.drjana.com/privacy-policy.html>. The notice of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment of my bills or in the performance of **Dr. Jana Joshu Grimm, DC** healthcare operations. The Notice of Privacy Practices also describes my rights and **Dr. Jana Joshu Grimm, DC's** duties with respect to my protected health information.

Dr. Jana Joshu Grimm, DC reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent to me by email or asking for one at the time of my next appointment.

Signature of Patient
(or personal representative)

DATE

Printed Name of Patient

Printed Name of Personal Representative

Legal Relationship of Personal Representative