

# EAST COUNTY CHIROPRACTIC

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## Acknowledgement of Receipt of Notice of Privacy Practices

This form represents documentation that East County Chiropractic's Notice of Privacy Practices was given to the patient or their personal representative.

By signing this form, you acknowledge receipt of East County Chiropractic's Notice of Privacy Practices. The notice provides information about how we may use and disclose your protected health information. You are encouraged to review the notice carefully.

***I acknowledge receipt of East County Chiropractic's Notice of Privacy Practices.***

Signature (patient or personal representative):

\_\_\_\_\_ Date:  
\_\_\_\_\_

If you are signing as a personal representative, please complete the following:

Parent/Guardian/Personal Representative's  
name: \_\_\_\_\_

Relationship to patient:  
\_\_\_\_\_