**Authorization to perform X-rays**

To the best of my knowledge I am **NOT** pregnant and Chestnut Chiropractic & Acupuncture Center has my permission to x-ray me for diagnostic interpretation.

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_

(Female Patient)

Chestnut Chiropractic & Acupuncture Center has my permission to take x-rays of me for diagnostic interpretation.

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_

(Male Patient)

**Privacy Practices (HIPPA)**

Acknowledgement Form

I have received or explained to regarding the Notice of Privacy Practices (HIPPA) law and I have been provided the opportunity to review the information if wanted.

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_