Receipt of HIPAA Notice of Privacy Practices

I hereby acknowledge that I have read and received a copy of the Herman Rus Medical Corporation dba Soft Reboot Wellness HIPAA Notice of Privacy Practices.

_____ _____

Signature Date

_____ _____

Print Name Telephone

If not signed by the patient, please indicate relationship:

- Parent or guardian of minor patient _____

  Name of Patient _____

Alternatively, you may print it and then fax it to us at (650) 419-9877.

For Office Use Only

A written signature of this form was attempted but could not be obtained because:

- ☐ Individual refused to sign
- ☐ An emergency situation prevented obtaining this acknowledgement
- ☐ Other _____

Witness _____ *(Printed Name of Practice Representative)*

Witness _____ _____

_____ _____

Signature Date