Dr. Steven Kraskow, DC, PA
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HIPAA AUTHORIZATION ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I have received a copy of the
Privacy Notice Summary.

Date: ____

Patient Name (Printed): ________________________________

Patient Signature: ____________________________________

Signature of Legal Representative (e.g., Attorney-In-Fact, Guardian,

Parent-if a minor): ____________________________________

Relationship: ____

Witness: ____