Dr. Shauna L. Olsen D.C.
Dr. Joseph D Pilloud D.C.
1699 S. Virginia Street Suite 100
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(775) 826-5575 Fax 775826 4494

Notice of Privacy Practices Receipt

I acknowledge that I was provided with the Notice of Privacy Practices of the medical practice named at the top of this page

Print Name of Patient ____

Date Of Birth ____

____

Signature of Patient Date

For Personal Representative of the Patient (if Applicable)

Print Name of Personal Representative ____

Relationship (parent , guardian, Power of Attorney, etc.____________________________

I hereby certify that I have the legal authority under applicable law to make this request on behalf of the patient identified above

____

Signature of Personal Representative Date