

MONTEREY BAY WELLNESS CENTER

MONTELLESE FAMILY CHIROPRACTIC, INC.

Dr. Christopher G. Montellese, D.C.

Dr. Kristina E. Montellese, D.C.

NOTICE OF PRIVACY PRACTICES

This notice effective as of _____.

I have read the Privacy Notice and understand my rights contained in this notice.

By my way of signature, I provide Kristina E. Montellese, D.C. or Christopher G. Montellese, D.C. with my authorization and consent to disclose my protected health care information for purposes of treatment, payment and healthcare operation as described in the Privacy Notice.

Patient Name (Print) _____
Date of Birth

Patient Signature _____
Date

If this authorization form is signed by a personal representative for the patient:

Representative's Name (print)

Signature of Representative _____
Date

Relationship to patient _____