Patient Acknowledgement of Receipt
Notice of Information Practices

PATIENT NAME	DATE OF BIRTH
ADDRESS	
CITY, STATE, ZIP CODE	TODAY'S DATE

I hereby acknowledge that I have received a copy of CHC Family Health Centers' Notice of Information Practices.

I understand that the Notice of Information Practices describes how CHC Family Health Centers use and disclose my medical and billing information. The Notice of Information Practices also describes how CHC Family Health Centers describes my rights and how I can receive additional information.

SIGNATURE OF PATIENT/ PARENT/ LEGAL REPRESENTATIVE	DATE	RELATIONSHIP TO PATIENT

Acknowledgment obtained by (employee only):

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Please print name and initial

Forward this document to the Dental Department for appropriate filing into the patient's medical record.

Below, document reason if acknowledgment of receipt is not obtained

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2/2019