Community Health Connections
We take great care of you!

Patient Acknowledge of Receipt
Notice of Privacy 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's Notice of Privacy Practices.

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

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

Acknowledgement obtained by: (CHC STAFF ONLY)

Please print name and initial

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

Below, document reason if acknowledgement of receipt is not obtained

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