CHARLOTTE COMMUNITY HEALTH CLINIC

MRN#_____

Notice of Privacy Practices
Receipt & Acknowledgement of Notice

Patients Name: _____

Date of Birth: _____

Social Security #: _____

I hereby acknowledge that I have received and given an opportunity to read a copy of the Charlotte Community Health Clinic's Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact the Administrative Office at 704-384-1980.

_____ _____

Patient Signature/Guardian/Personal Representative **Date**

_____ _____

Signature of Staff Member **Date**