256 Beacon Ridge Blvd.
Chapel Hill, NC 27516

RECEIPT OF NOTICE OF PRIVACY PRACTICES

The attached notice describes how medical information about you may be used and disclosed, and how to get access to this information. Please review this notice carefully.

I have received and reviewed the attached NOTICE OF PRIVACY PRACTICES.

Signature of Patient (age 12 and over)	Date
Print Name	Patient's Date of Birth
Signature of Parent/Guardian (under age 18)	Relationship to Patient
Witness	Date