Valley Professionals Community Health Center
CARING PROFESSIONALS IN YOUR COMMUNITY.

_____

Please Print: First Name M.I. Last Name

Acknowledgment of Receipt of Patient Bill of Rights

By my signature below, I acknowledge that I have received the Patient Bill of Right.

_____ _____

Signature Date

_____ _____

Relationship to patient (if not signed by patient) Staff initials

Acknowledgment of Receipt of Notice of Privacy Practice

By my signature below, I acknowledge that I have received the Patient Bill of Right.

_____ _____

Signature Date

_____ _____

Relationship to patient (if not signed by patient) Staff initials

3.17.14