



### Acknowledgement of Receipt of Notice of Privacy Practices

**\*\*You may refuse to sign this acknowledgement\*\***

I have reviewed a copy of this office's Notice of Privacy Practices and the state of Wisconsin Addendum. By signing this form, I am confirming my written permission for the disclosure of my protected health information (PHI).

\_\_\_\_\_  
**Print Your Name (First, Last, Middle Initial)**

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**

#### **Please Read The Following Information**

You have the right to read our privacy practices notice before you decide to sign this consent. Our notice provides a description of the uses and disclosures we may make of your protected health information. A copy of our notice accompanies this consent. We encourage you to read it carefully before signing.

This consent is a condition of your treatment by us. If you decide not to sign this form, we may decline treatment to you. (Persons 18 and older must sign their own form.)

You have the right to revoke this form at any time, by giving written notice to the contact person listed in our notice.

Please list below any person you give permission to assist with your healthcare needs/financial obligations including discussing treatment, billing and insurance. If none, please write "none".

_____	_____
_____	_____
_____	_____
_____	_____

#### **For Office Use Only**

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual Refused to Sign     
 Communication barriers prohibited Obtaining the Acknowledgement     
 An emergency situation Prevented us from obtaining Acknowledgement.