

**Acknowledgement
For
Receipt of Privacy Practices**

This form is a receipt noting that you have received the UW Health Notice of Privacy Practices.

Name of Patient: _____
[Please Print]

Date of Birth: _____

Address: _____

Date of Service: _____

Or, If Available,
Affix
Cover or Bar Code Label
Here

I have received a copy of the UW Health Notice of Privacy Practices.

[Signature] [Date of Receipt]

If this form is being signed for a minor, an incompetent or otherwise incapacitated or deceased person, please fill in the following information.

Legally Authorized Representative's Name _____
[Print Name]

Patient is: Minor Incompetent or Incapacitated Deceased

Legal Authority: Legal Guardian Parent of Minor Other _____

Health Care Agent _____

Personal representative of deceased [Executor, next of kin, or other family member]

For Office Use Only:

- Signature Declined
- Signature Not Obtained Due to Patient Incapacitation
- Patient Signed Acknowledgement at Another UW Health Site _____

I personally delivered the Notice of Privacy Practices to the patient listed above. The patient declined to sign this Acknowledgement on the basis noted above.

[Signature of Office Staff Member] [Date]

Name: _____
[Please Print]

Title: _____