MILWAUKEE
MKE WI
DENTAL ARTS

2700 W. Lincoln Ave.
Milwaukee, WI 53215

Section A: **Patient**

Name: _____

Address: _____

Phone #: _____ Email: _____

Social Security #: _____

Section B: Acknowledgement of Receipt of Privacy Practices Notice:

I, _____, acknowledge that I have received a Notice of Privacy Practices from the above-practice.

Signature: _____ Date: _____

If a personal representative signs this authorization on behalf of the individual, complete the following:

Personal Representative's Name: _____

Relationship to Individual: _____

Section C: Good Faith Effort to Obtain Acknowledgement of Receipt.

Describe your good faith effort to obtain the individual's signature on this form: _____

Provided patient with HIPPA Private Practice Policy form & explained importance of it.

_____

Describe the reason why the individual would not sign this form: _____

_____

_____

Signature:
I attest that the above information is correct.

Signature: _____ Date: _____

Print Name: _____ Title: _____

Include this acknowledgement of receipt in the individual's records.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE