# Acknowledgement of Receipt of Notice of Privacy Practices

## University of Wisconsin-Milwaukee
## [Covered Department Name and Contact Information]

Patient Name (print): _____

Date of Birth: _____

I, the patient, acknowledge that the above-listed Department of the University of Wisconsin-Milwaukee has given me a copy of its Notice of Privacy Practices, which explains how my Protected Health Information will be used and disclosed in various situations.

_____ _____
Signature of patient or parent or legal guardian Date

_____
Printed name of patient

_____
Printed name of parent or legal guardian (if applicable)

_____
Relationship to patient (if applicable)

**For clinician use only:**

If unable to obtain acknowledgement, please document dates and circumstances of attempts below. Use the back of this sheet for additional documentation if necessary.

| | Date of attempt: | Circumstances prohibiting completion of Acknowledgement: |
|---|---|---|
| 1) | _____ | _____<br>_____<br>_____ |
| 2) | _____ | _____<br>_____<br>_____ |
| 3) | _____ | _____<br>_____<br>_____ |