

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE**



I acknowledge that I have received from **MILWAUKEE SURGICAL SPECIALISTS, S.C.** (the “Practice”) a written **Notice of Privacy Practices** concerning the confidentiality of my protected health information. I acknowledge that the written Notice contains a description of how medical information about me maybe used and disclosed and how I may access this information. I acknowledge that the Notice also contains:

- A description of the types of uses and disclosures that the Practice is permitted to make for treatment, payment or healthcare operations with and without my written authorization.
- A description of each of the other purposes for which the Practice is permitted or required to use or disclose PHI without my written authorization.
- A description of uses or disclosures that may be limited or prohibited by law.
- Descriptions that are in sufficient detail to make me aware of the uses or disclosures that are permitted or required by the federal privacy rules and other applicable laws.
- A statement describing my individual rights with respect to my health information and a description of how I may exercise this right.
- A statement describing the Practice’s duties under the federal privacy law.
- A statement describing how I may express concern to the Practice and the Secretary of the federal Department of Health and Human Services if I believe my privacy rights have been violated.
- Information explaining how to contact the Practice for further information and the effective date upon which the Notice is first in effect.

I, the undersigned, acknowledge that I have received a written Notice of Privacy Practices from **MILWAUKEE SURGICAL SPECIALISTS, S.C.**

\_\_\_\_\_  
*(Signature of Patient or Personal Representative)*

\_\_\_\_\_  
*(Date)*

\_\_\_\_\_  
*(Print Patient Name)*

If Personal Representative, describe relationship: \_\_\_\_\_

**For Office Use Only:**

\_\_\_ The patient’s condition prevents the individual from signing an acknowledgement at this time. It will be obtained as reasonably practicable after the patient’s condition improves.

\_\_\_ Acknowledgement was unable to be obtained. Reason: \_\_\_\_\_

\_\_\_\_\_