Name:
DOB:
Chart:
Age:
Date:

HAND TO SHOULDER SPECIALISTS OF WISCONSIN

Written Acknowledgement of Receipt

I, ______________________________ acknowledge that I am aware of the
Patient Name

Notice of Privacy Practices from Hand to Shoulder Specialists of Wisconsin.

______________________________ ______________
Patient or Personal Representative Signature Date

____
If Personal Representative, describe relationship

☐ The patient's condition prohibits 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:

____

____

____

______________________________ ______________
Employee Signature Date