

Name:
DOB:
Chart:
Age:
Date:



HAND TO
SHOULDER
SPECIALISTS
OF WISCONSIN

Written Acknowledgement of Receipt

I, _____ acknowledge that I have received the written
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