WISCONSIN HEALTH FUND (DENTAL CENTER)

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

Patient Name: _____

Today's Date: _____

☐ I have received a copy of Wisconsin Health Fund's *Joint Notice of Privacy Practices* Policy

_____ _____

Patient / Guardian Signature Date

FOR OFFICE USE ONLY

To be completed by the WHF staff if acknowledgement form is not signed by patient

- Does the above named patient have a copy of Wisconsin Health Fund's *Joint Notice of Privacy Practices* Policy?

☐Yes ☐No

- Please state why a signature was not obtained and what efforts you made to obtain the patient's signature:

_____

_____

_____ _____

WHF Staff Signature Date

Wisconsin Heath Fund (Dental Center) • 6200 W. Bluemound Rd • Milwaukee, WI 53213
414-755-8325 Ph • 414-475-7386 Fax

Updated 11/30/11