



WISCONSIN HEALTH FUND (DENTAL CENTER)
ACUSE DE RECIBO DE LA POLÍTICA DE PRIVACIDAD

Nombre del paciente: _____
Fecha de hoy: _____

He recibido una copia del Aviso Conjunto Wisconsin Health Fund's de Privacidad Prácticas

Paciente / Tutor

Fecha

FOR OFFICE USE ONLY (PARA USO EXCLUSIVO DE)

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