# WISCONSIN HEALTH FUND
## ACKNOWLEDGEMENT OF RECIEPT OF PRIVACY NOTICE

Patient Name:________________________________

Medical Record Number__________________________

Date: ____________________

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

Patient Signature — Date

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**To be completed by WHF staff if acknowledgement form is <u>not</u> signed by patient.**

1. Does the above named patient have a copy of Wisconsin health Fund's Notice of Privacy Practices?

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

__________________________________________________________

__________________________________________________________

WHF Staff — Date