

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 <u>Joint Notice of Privacy Practices</u> Policy

Date

Patient / Guardian Signature

<u>FOR OFFICE USE ONLY</u> 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 <u>Joint Notice of</u> <u>Privacy Practices</u> Policy?
\Box Yes \Box 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