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# HIPAA NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT FORM

**Regulations require that we make a "good faith" effort to provide you with a copy of our HIPAA Privacy Practices Notice. However, you are not required to accept the Notice, only to acknowledge that we have made you aware of our HIPAA Notice of Privacy Practices.**

I, _____, have received a copy of,
[Patient Name]
or acknowledge the existence of Endodontic Specialists of Wisconsin HIPAA Notice of Privacy Practices.

_____ _____
Patient Signature Date

I give my permission to release my medical information to:

_____/ _____/_____
Name Relationship Phone Number

_____/ _____/_____
Name Relationship Phone Number

***FOR OFFICE USE ONLY***

*WHEN EFFORTS TO OBTAIN PATIENT ACKNOWLEDGEMENT WERE UNSUCCESSFUL:*

NAME OF PATIENT: _____
I provided the above-named patient with the HIPAA Notice of Privacy Practices for Endodontic Specialists of Wisconsin on _____.
Date

Describe how Notice was offered or provided:
[ ] Offered copy and patient refused to accept delivery.
[ ] Offered copy and patient accepted delivery but refused to sign.
[ ] Other [describe]:
_____

_____ _____
Employee Signature Date

REV. 06/01/23

7500 Green Bay Road
Kenosha, WI 53142
262-842-7022

10401 West Lincoln Avenue
Milwaukee, WI 53227
414-546-1900

10532 N. Port Washington Road
Mequon, WI 53092
262-241-8300

3314 Superior Avenue
Sheboygan, WI 53081
920-452-9550

519 Midland Court
Janesville, WI 53546
608-755-9900

1185 Corporate Center Drive #330
Oconomowoc, WI 53066
262-567-7840