

Waukesha Surgical Specialists, S.C. (WSS)

Written Acknowledgment of Receipt

I, _____, acknowledge that I have received the written
PRINT Patient Name

Notice of Privacy Practices from WSS.

Signature of Patient or Personal Representative

Date

If Personal Representative, describe relationship

- The patient's condition prohibits the individual from signing an acknowledgment at this time. It will be obtained as reasonably practicable after the patient's condition improves.

- Acknowledgment was unable to be obtained. Reason: _____

Employee Signature

Date

Waukesha Surgical Specialists, S.C. (WSS)

Consent to Use and Disclose Protected Health Information

I consent to the use or disclosure of my protected health information by WSS for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct the health care operations of WSS.

By signing this form, I give consent for WSS to use and/or disclose my health information for treatment, payment or health care operations.

Print Name of Patient or Personal Representative

Date

Signature of Patient or Personal Representative

Date

Description of Personal Representative's Authority