

**ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES**

University Orthopaedic Services, Inc.

By signing below, I acknowledge that I have been provided a copy of University Orthopaedic Services, Inc.'s Notice of Privacy Practices.

Signature

Patient Name or Personal Representative (please print)

Date

Description of Personal Representative's Authority

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

Individual refused to sign

Communication barriers prohibited obtaining the acknowledgement

An emergency situation prevented us from obtaining acknowledgement

Other (Please Specify):

Effective Date of Notice of Privacy Practices Provided to the Patient
