Aurora BayCare Medical Center

Green Bay, Wisconsin

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT FORM

Patient Name: ______________________________________

Date of Birth: ______________________________________

Medical Record #: ___________________________________

I acknowledge that Aurora BayCare Medical Center has provided me a copy of its Notice of Privacy Practices.

____ ________________

Patient Signature Date

FOR OFFICE USE ONLY

If unable to obtain the patient's signature, please provide the reason below:

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__________________________ __________________________ ______________

Name Title Date

AHC X20764.j (04/01/03)
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