

Timothy O. Hart  
1720 E. Lake Bluff Blvd.  
Shorewood, WI 53211

**Section A: The Patient**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

**Section B: Acknowledgement of Receipt of Privacy Practices Notice**

I (name) \_\_\_\_\_, acknowledge that I have received a Notice of Privacy Practices from the above-named practice.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*If a personal representative signs this authorization on behalf of the individual, complete the following:*

Personal Representatives Name: \_\_\_\_\_

Relationship to Individual: \_\_\_\_\_

**For Office Use Only:**

I attest that the above information is correct.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_ Title: \_\_\_\_\_