# Acknowledgement of Receipt of HIPAA Patient Privacy Practices

I acknowledge that Integrated Spine Care has provided a copy of ***Notice of Privacy Practices***. This document describes how medical information is protected, how it may be used and disclosed. I have read and understand the contents of this document.

Patient Name: ___________________________________

Date of Birth: ___________________________________

Signature: ___________________________________

Date: _________________________

Or signature of other person legally authorized to consent: _________________________________________

Name of patient's representative: _____________________________________________

Integrated Spine Care, 601 N 99th Street Suite 101, Wauwatosa, WI 53226 Ph (414) 988-5100 Fax (414) 988-5102