GUNDERSEN HEALTH SYSTEM®

Acknowledgment of Receipt
Notice of Privacy Practices

Adult Patient	**Dependent Patient(s)** (Minor Child, Other Dependent Persons)
(Please Print)	*(Please Print)*
Clinic Number: _____	Clinic Number: _____
Name: _____	Name: _____
Date of Birth: _____	Date of Birth: _____
	Clinic Number: _____
	Name: _____
	Date of Birth: _____
	Clinic Number: _____
	Name: _____
	Date of Birth: _____

I acknowledge that I have received a copy of Gundersen Health System's Notice of Privacy Practices.

_____

Signature Date

_____

(Relationship, if signed on behalf of a dependent person or minor child.)

Please return this form within 10 days to:

Gundersen Health System
CBO-002
1900 South Avenue
La Crosse, WI 54601