

**ACKNOWLEDGMENT OF OUR NOTICE OF PRIVACY PRACTICES**

I hereby acknowledge that I have received or have been give the opportunity to receive a copy of Alaska Hand-Elbow-Shoulder’s Notice of Privacy Practices. By signing below I am “only” giving acknowledgment that I have received or have had the opportunity to receive the Notice of our Privacy Practices.

\_\_\_\_\_  
Patient Name (Type or Print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature