



Castle Orthopaedics & Sports Medicine, S.C.  
And  
Castle Surgicenter LLC

ACKNOWLEDGEMENT OF RECEIPT OF  
NOTICE OF PRIVACY PRACTICES

I, \_\_\_\_\_, give permission to any member of the staff of Castle Orthopaedics and Sports Medicine, S.C. and/or Castle Surgicenter LLC to release PHI (Protected Health Information) to the following family member(s):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I, \_\_\_\_\_, have received the Notice of Privacy Practices from Castle Orthopaedics & Sports Medicine, S.C. and/or Castle Surgicenter LLC.

X \_\_\_\_\_ Date: \_\_\_\_\_

In lieu of patient signature, I, \_\_\_\_\_, a staff member of Castle Orthopaedics & Sports Medicine, S.C. and/or Castle Surgicenter LLC, state that \_\_\_\_\_ has been given our current Notice of Privacy Practices.

X \_\_\_\_\_ Date: \_\_\_\_\_