



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

ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES

I, _____, _____ of
(Relationship to Patient)
_____, give permission to any
(Patient Name)

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: _____