



Acknowledgment of Receipt of Notice and Approval of Privacy Practices

I, \_\_\_\_\_, hereby acknowledge that I have received the corresponding HIPAA Notice of Privacy Practices. I also further acknowledge and approve the uses and disclosures of my PHI as described in the HIPAA Notice of Privacy Practices.

Date: \_\_\_\_\_ .20 \_\_\_\_\_  
Signature of Patient or Representative

Patient Contact Authorization

I, \_\_\_\_\_ (Please Print Name) authorize and give permission to William Power, M.D., or any practice staff members, to leave messages regarding my medical information on the following telephone(s):

Home: ( ) \_\_\_\_\_

Cell: ( ) \_\_\_\_\_

I authorize and give permission to William Power, M.D. or any practice staff member, to speak with the following people regarding my medical status and/or treatment:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Patient Signature: \_\_\_\_\_

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