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 **MMG, Atlantic Women's Medical Group**, 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 **MMG, Atlantic Women's Medical Group**, 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: _____

For Internal Use Only:
Scan document once after 8/1/14 into HIPAA form folder in CB

Revised 11/15