Hackensack Meridian *Health* Medical Group

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 Hackensack Meridian *Health* 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 (insert practice name), 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:

Revised 2/18