



***Acknowledgement of Receipt of Notice and Approval of Privacy Practices***

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

Date: \_\_\_\_\_, 20\_\_\_\_\_

\_\_\_\_\_  
Signature of Patient/Parent or  
Representative

***Patient Contact Authorization***

I, \_\_\_\_\_ (please print name) authorize and give permission for practice staff of Strong at the Core LLC to leave messages regarding my medical information on the following telephone(s):

Home: \_\_\_\_\_

Cell: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

I give permission to receive text messages on my phone for the purposes of scheduling and re-scheduling appointments, or for appointment reminders. \_\_\_\_\_ (Initial)

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_