Jennifer S. Williams, DDS
8580 River Road SE
Southport, NC 28461

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I,_______________________________________, have read a copy of Dr. Williams' notice of Privacy Practices.

Please Print Name

____

Signature

____

Date

____

I hereby authorize Dr. Williams and her staff to release health information to the following family member(s): (such as spouse, parent, or other person living in your household)

1.______________________________________ Phone:________________________

2.______________________________________ Phone:________________________

3.______________________________________ Phone:________________________

Dr Williams and her staff

- o Have
- o Do not have

my permission to leave information regarding appointments or lab work on the answering machine.