

## **Patient Consent to Release Medical Information**

I wish to designate the following person(s) to be able to speak on my behalf and have access to my **protected health** information:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

## **Privacy Notice Acknowledgement**

I acknowledge that I have been provided with a copy of William Purtil, M.D. privacy notice.

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date

