PATIENT ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICE

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

By signing below, I acknowledge that I have read ENT's Notice of Privacy policy.

I wish to be contacted in the following manner.
Check all that apply:

- ☐ Home Telephone_____
  OK to leave message with detailed information.
- ☐ Leave message with call-back number only
- ☐ Work Telephone_____
- ☐ OK to leave message with detailed information.
- ☐ Leave message with call-back number only.
- ☐ OK to fax to this number
  _____

You can communicate information about me to:
Check all that apply:

- ☐ My Spouse
- ☐ Family Members
- ☐ Caregivers_____
  _____
- ☐ Others_____
  _____

_____

Patient or Legal Guardian Signature Date

_____

Print Patient Name Relationship to Patient and Patient Date of Birth

FOR OFFICE USE ONLY:

RECORD OF DISCLOSURES OF PROTECTED HEALTH INFORMATION
Not necessary to record disclosures for TPO purposes.
(A) Check to confirm Patient Authorization Received

Date	Disclosed to Whom or Fax Number	(A)	Description of Disclosure Purpose of Disclosure	By Whom Disclosed	Method-Mail, Fax, Email etc.