

**PRIVACY PRACTICES ACKNOWLEDGEMENT**

PATIENTS NAME: \_\_\_\_\_ BIRTHDATE \_\_\_\_\_

*Please fill out the following information and sign.*

Specialist in Ear, Nose and Throat **MAY** leave private health information, on an answering machine or voice mail, regarding the above named patient.

Please list phone numbers we may contact you or leave messages at.

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

Work: \_\_\_\_\_

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

If patient is a minor, parent or guardians name: \_\_\_\_\_

Lists of persons or family members whom we may leave private health information with.

\_\_\_\_\_ relationship \_\_\_\_\_

\_\_\_\_\_ relationship \_\_\_\_\_

I have been provided an opportunity to review the Notice of Privacy Practices and understand the contents of this form.

Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_