NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT
CENTURY EAR, NOSE & THROAT – HEAD AND NECK SURGERY

I understand that under the Health Information Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

_____ _____
PATIENT NAME (PRINT) DATE OF BIRTH

_____ _____
SIGNATURE DATE

_____ _____
I DECLINE TO SIGN DATE

_____
REASON FOR DECLINING TO SIGN

	Circle One
Test results may be left on my answering machine.	YES NO
Appointment information may be left on my answering machine.	YES NO

AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____, will allow my health information, test
PATIENT NAME
results, and billing questions to be discussed with the following people (such as spouse, children, friend):

Person	**Relationship**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

_____ _____
PATIENT/PARENT/GUARDIAN SIGNATURE DATE