

CHESAPEAKE EAR NOSE & THROAT, P.A.

PATIENT ACKNOWLEDGEMENT FORM

Use & Disclosure of Protected Health Information

Chesapeake Ear Nose & Throat, P.A. "Notice of Privacy Practices" provides information about how we may use and disclose protected health information about you. Please acknowledge receipt of this office's Notice of Privacy Practices by initialing below:

Patient's initials

I authorize that Chesapeake Ear Nose & Throat, P.A. may disclose health information and billing information to the following person or persons:

Patient's signature

Our Notice of Privacy Practices states that we reserve the right to change the terms described. Should this happen, you will receive a revised copy at your next office visit.

Patient's initials

You have the right to request restriction on how your protected health information may be used or disclosed for treatment, payment, or health care operations. We are not required to agree to your restrictions, but if we do, we are bound by our agreement with you.

Patient's initials

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in trust on your prior consent.

Patient Name

If Minor-Parent/ Legal Guardian Name

Patient/Parent/Legal Guardian Signature

Date