

Acknowledgement of Receipt of Notice of Privacy Practices

In general, any information that is about your health, the health care you receive, or payment for that care is considered confidential and protected by our practice. We may need to use your protected health information to carry out treatment, payment, healthcare operations, and/or other purposes. Our Notice of Privacy Practices provides a more complete description of permitted uses and disclosures.

Please sign below to acknowledge that you have received a copy of our Notice of Privacy Practices

Signature of patient, parent or guardian

Date

Printed name of parent or guardian: _____

Relationship to patient: _____

Release of Information to Family and Friends

Huntington Ear, Nose & Throat Specialists, PLLC has my permission to release medical information about me to the following people:

Name and Relationship

Date

Name and Relationship

Date

Name and Relationship

Date

Do not release any medical information about me to the following people:

Name and Relationship

Date

Name and Relationship

Date

Name and Relationship

Date

DO NOT release information about me to anyone.

Patient, parent or guardian

Date

Witness

Date