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# NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT

By signing this, I acknowledge that I have received a copy of Eastern Oklahoma Ear, Nose & Throat's Notice of Privacy Practices.

Patient's Name: \_\_\_\_\_

Account #: \_\_\_\_\_

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

If the signature above is not the patient, please state your relationship to the patient.

Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

### Release of Protected Health Information

Information may be released to the following individual(s)

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

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

*\*You may revoke this authorization at any time by sending written notice to: Administrator, Eastern Oklahoma Ear, Nose & Throat at 5020 East 68th Street South, Tulsa, Oklahoma 74136. Your notice will not apply to action taken prior to our office receiving written request to revoke authorization.*

I authorize confidential messages containing my Protected Health Information to be left on:

My answering machine at home Phone#: \_\_\_\_\_

My answering machine at work Phone#: \_\_\_\_\_

My cell phone Phone#: \_\_\_\_\_

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### Office Use Only

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Employee Initials: \_\_\_\_\_ Date: \_\_\_\_\_

Comments: \_\_\_\_\_