Acknowledgement Of Receipt Of Notice Of Privacy Practices

I have been advised that a copy of the Notice of Privacy Practices is available in the waiting room. I acknowledge that I may request a copy of the Notice of Privacy Practices for Northern Valley ENT. I agree by providing any contact phone numbers that it is permissible to leave messages regarding my care in this office, including but not limited to test results. I may also receive mail related to my treatment at the address provided.

Print Patient Name_____

Signature of Patient_____ Date_____

You may release medical information to:

- ☐ Parent
- ☐ Child
- ☐ Spouse
- ☐ Other_____

If person signing is not the patient, please print your name and relationship to patient:

Name_____

Relationship_____

I,_____request a copy of the Notice of Privacy Practices:

☐ Yes ☐ No

For Office Use:

If patient /representative requested copy of Notice, date copy was provided:_____

If no acknowledgement could be obtained, state reasons why and the efforts taken to try to obtain acknowledgement:

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