Mile High Otolaryngology, LLC.

Acknowledge of Notice of Privacy Practices

I hereby acknowledge that I received Mile High Otolaryngology's Notice of Health Information Privacy Practices.

_____ _____

Patient Name (Please Print) **Date of Birth**

_____ _____

Signature of Patient or Representative **Date**

Contact Person with whom we may discuss your care and give results.

_____ _____ _____

Name **Relationship** **Phone Number**

_____ _____ _____

Name **Relationship** **Phone Number**

May we leave confidential information on voicemail or answering machines listed below?

Home Phone_____ Yes_____ No_____
Work Voicemail_____ Yes_____ No_____
Cell Voicemail_____ Yes_____ No_____