

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