

## **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	
May we leave o	confidential information on v	oicemail or answering machines li	sted below?	
Home Phone	☐ Yes ☐ No			
Work Phone	☐ Yes ☐ No			
Cell Phone	□ Yes □ No			
Contact Persor	n with whom we may discus	s your care and give results.		
Name		Relationship	Phone Number	
Name		Relationship	Phone Number	