MILE HIGH
OTOLARYNGOLOGY

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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 confidential information on the answering machines or voicemails listed below?

Home Phone ☐ Yes ☐ No

Work Phone ☐ Yes ☐ No

Cell Phone ☐ Yes ☐ No

Contact person(s) with whom we may discuss your care and give results.

Name _____ Relationship _____ Phone Number _____

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