You may type directly on this form. When you are finished, please print it out, sign it and bring it with you on the day of your visit.

Virginia Ear, Nose & Throat Associates, P.C.

Patient #: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have received a copy of the "Notice of Privacy Practices" for Virginia Ear, Nose & Throat Associates, P.C. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy. This notice is available in our office.

I understand that I may access my medical records at any time and that I may copy and/or inspect my PHI to be used or disclosed in accordance with Virginia Ear, Nose & Throat Associates' policy. I understand that Virginia Ear, Nose & Throat Associates may charge me for copies of such records, or completion of medical record forms, however a fee schedule will be provided to me.

I understand that Virginia Ear, Nose & Throat Associates has the right to deny me access to my records in certain circumstances, in accordance with the law; however, in such instance they will provide me with a denial in writing.

AUTHORIZATION FORM FOR USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. It has been explained to the patient that disclosures may be made to family and friends related to the patient's health. It has also been explained that we will only disclose information relevant to current treatment. Our patient has agreed that we will only disclose health care information to (list all that apply):

	In Person	**By Phone**
Spouse Name: _____	☐	☐
Parent(s) Name: _____	☐	☐
Sibling(s) Name: _____	☐	☐
Other: _____ (Name) (Relationship)	☐	☐

Expiration Date of Authorization:____/____/_____ or ☐ until otherwise specified

I, _____, authorize the use or disclosure of my PHI as specified in the Notice of Privacy Practices for Virginia Ear, Nose & Throat Associates, P.C. I understand the purpose of the authorized use of disclosure of PHI is for use within Virginia, Ear, Nose & Throat Associates, P.C. or for authorized disclosure from another entity that is subject to the privacy rule to Virginia Ear, Nose & Throat Associates, P.C. for treatment, payment or health care operation purposes. I also understand that if the organization authorized to receive my PHI is not a health plan or health care provider, that organization may disclose my PHI. In the event that this happens, I understand that my information may no longer be protected under the federal privacy rule and regulations. I understand that this authorization is voluntary and may be revoked at any time. I understand that I may ask questions of Virginia Ear, Nose & Throat Associates, if I do not understand any information contained in the Notice of Privacy Practices.

_____ _____
(Printed Name of Patient) (Date)

_____ _____
(Signature of Patient or Patient's Representative) (Date)

_____
(Printed Name of Patient's Representative) (Relationship)