Associates in Ear, Nose, Throat/Head and Neck Surgery, PLLC

Receipt of Notice of Privacy Practices Written Acknowledgment Form

I, ____, have

Signature of Patient or Legal Guardian

received/offered a copy of the Associates in Ear, Nose, Throat/Head and Neck Surgery, PLLC's Notice of Privacy Practices.

______________________________________ ______________

Signature of Patient or Legal Guardian Date

Please list any family members/significant other that you wish the physician or their designated staff member to review or discuss your Medical Information with.

______________________________________ ______________

Name of Family Member/Significant Other Your Initials Date