CAPE ENT
Allergy · Audiology · Aesthetics
Facial Plastic Surgery · Dermatology

Acknowledgment of Receipt of Notice of Privacy Practices

I, _____ , was offered and:

☐ I have received a copy of the "Notice of Privacy Practices" for Cape ENT.

☐ I have declined a personal copy of the "Notices of Privacy Practices" for Cape ENT.

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 posted in our offices, on our website, and copies are available at any time. I understand that I may ask questions of Cape ENT if I do not understand any information in the Notice of Privacy Practices.

I understand that I may access my medical records at any time and that I may copy and/or inspect my protected health information (PHI) to be used or disclosed in accordance with Cape ENT's policy. I understand that Cape ENT 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 Cape ENT 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 denial in writing.

AUTHORIZATION FORM FOR USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION

The Notice of Privacy Practices provides information about how Cape ENT may use and disclose my PHI. Disclosures may be made to family and friends related to my health. Cape ENT will only disclose information relevant to current treatment. By signing below, I authorize Cape ENT to only disclose health care information to the following individuals (list all that apply):

	In Person	By Phone
1. _____	☐	☐
2. _____	☐	☐
3. _____	☐	☐
4. _____	☐	☐

(name) (relationship)

Expiration Date of Authorization: _____ /_____ /_____ OR ☐ until otherwise specified

Cape ENT has my permission to leave medical information or messages on my:

☐ Home answering machine _____ (home phone number)

☐ Cellphone voicemail _____ (cellphone number)

_____ _____
Printed Name of Patient Date

_____ _____
Signature of Patient or Patient's Representative Date

_____ _____
Printed Name of Patient's Representative Relationship