EASTERN SHORE ENT & Allergy ASSOCIATES, P.A.
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# *PATIENT HIPAA ACKNOWLEDGMENT FORM*

**Use & Disclosure of Protected Health Information**

**Patient Name**_____ **Date of Birth** ____/____/_____

**Eastern Shore ENT & Allergy Associates, P.A.**'s "Notice of Privacy Practices" provides information about how we may use and disclose protected health information about you. Please acknowledge review and receipt, if requested, of this office's **Notice of Privacy Practices** by initialing below:

_____ ( Patient/Legal guardian)

Our **Notice of Privacy Practices** states that we reserve the right to change the terms described. Should this happen, you will receive a revised copy, if requested, either by mail or at your next appointment.

_____ (Patient/Legal guardian)

You have the right to request restrictions on how your protected health information may be used or disclosed for treatment, payment, or health care operations. We are not required to agree to your restrictions, but if we do, we are bound by our agreement with you.

_____ (Patient/Legal guardian)

By signing this form, you consent to our use, disclosure and receipt of protected health information about you for treatment, payment, and health care operations. Other than activities that have already occurred, you may revoke any further authorizations to use or disclose your health information.

**Eastern Shore ENT & Allergy Associates, P.A.** is authorized to discuss my medical health and treatment with:

_____
Name and Relationship of Individual (s) (if no one state "no one")

_____
Name and Relationship of Individual

_____
Name and Relationship of Individual

_____
Name and Relationship of Individual

_____
***Signature Patient/Legal guardian*** ***Date***

Revised June 2019