

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 your protected health information. Please acknowledge your 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

Signature Patient/Legal Guardian

Date

Revised December 2023