

**Orlando Ear, Nose & Throat Associates, PA**

Acknowledgement Form

Our notice of Privacy Practices provides information about how we may use and release protected health information about you. You have the right to review our Notice before signing this form. As provided in our Notice, its terms may change without notice. Any changes may be obtained by requesting a revised copy from our practice or staff.

You have the right to restrict how we disseminate your protected health information. This includes treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and release of protected health information about you for treatment, payment, and health care operations as described in our Notice. You have the right to revoke this consent, in writing, except where we have already made releases in reliance on your prior consent.

Patient Name \_\_\_\_\_

Signature of Patient/Authorized Agent \_\_\_\_\_

Date \_\_\_\_\_

\_\_\_\_ Refusal to sign Acknowledgment \_\_\_\_\_

Signature of staff