FLORIDA
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OTOLARYNGOLOGY – HEAD & NECK SURGERY – EAR & SINUS SURGERY – FACIAL PLASTIC & SKIN CANCER SURGERY – THYROID SURGERY

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have read and had an opportunity to ask questions concerning the above named practice's Notice of Privacy Practice.
This is to acknowledge that you have authorized us to:
1. Leave a detailed message, which may include test results, diagnosis or billing information on voicemail / answering machine. ☐ **Yes** ☐ **No**

2. If not at home, leave a detailed message with individual answering the phone, which may include test results, diagnosis or billing information. ☐ **Yes** ☐ **No**

Please name individuals that you hereby authorize on your behalf to speak with this office regarding all aspects of your medical chart, i.e., health conditions, medications, results and financial history.

NAME: _____ **RELATIONSHIP:** _____

NAME: _____ **RELATIONSHIP:** _____

NAME: _____ **RELATIONSHIP:** _____

Patient or Patient Representative **Print Patient's Name** _____

_____ **If signed by Representative, state name of**
Signature

Date: _____ **Representative**_____