PATIENT ACKNOWLEDGEMENT FORM

Chesapeake Ear, Nose, and Throat: A Division of CAdENT LLC, "Notice of Privacy Practices" provides information about how we may use and disclose protected health information about you. Please acknowledge receipt of this office's Notice of Privacy Practices by initialing below:

Patient Initials _____

Our Notice of Privacy and HIPAA Practices states that we reserve the right to change the terms described. Should this happen, you will receive a revised copy at your next office visit or you may request a copy at any time.

Patient Initials _____

You have the right to request restriction 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 Initials _____

By signing this form, you consent to our Notice of Privacy and HIPAA Practices Policy. You have the right to revoke this consent, in writing, except where we have already made disclosures in trust on your prior consent.

_____

Patient Name Parent/ Legal Guardian Name (if Minor)

_____

Patient/Parent/Legal Guardian Signature Date