

Lone Star ENT Specialists, PA

***Acknowledgement of Review of
"Notice of Privacy Practices"***

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

I ***DO*** give permission to discuss my medical history with: *(Please Provide First & Last Name)*

- Mother: _____
- Father: _____
- Spouse: _____
- Sister: _____
- Brother: _____
- Daughter: _____
- Son: _____
- Other: (please specify) _____

Please Print Patient's Name

Signature of Patient/Parent/Guardian

Relationship to Patient

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining the acknowledgement
- Other (please specify) _____