Atlanta ENT Sinus and Allergy Associates, P.C.

I ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice, You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of the office's Notice of Privacy Practices.

_____

Please print your name here

_____

Signature

_____

Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- The patient refused to sign.
- Due to an emergency situation it was not possible to obtain an acknowledgement.
- We weren't able to communicate with the patient.
- Other (Please provide specific details)

_____

_____

_____

_____

Employee signature

_____

Date

HIPAA Acknowledgement of Receipt of the Notice of Privacy Practices This form does not constitute legal advice and covers only federal, not state, law.

Atlanta ENT, Sinus & Allergy Associates, P. C.

Authorization For Use / Disclosure of Protected Health Information

I Authorize The Use/Disclosure of Health Information About Me As Described Below.

Patient's Name:_____

Patient's Birth Date:_____

Patient's SSN:_____

A. Person(s) or Organization(s) authorized to provide the information:

_____

Atlanta ENT, Sinus & Allergy Associates, P.C

B. Person(s) or Organization(s) authorized to receive the information.

_____

_____

C. Specific description of the information that may be used or disclosed (including date (s)):

_____

_____

D. Specific description of how the information will be used:

_____

_____

1. I understand that this authorization will expire on _____
2. I understand that I may revoke this authorization (except to the extent that action was already taken in reliance of this signed authorization) of any time by notifying _____ in writing.
3. I understand that I can refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment, payment or my eligibility for benefits (if applicable).
4. I may inspect or copy any information used or disclosed under this agreement.
5. I understand that if the person or organization that receives the information is not a healthcare provider or plan covered by federal privacy regulations, the information described above may be redisclosed and would no longer be protected by these regulations.

_____ _____

Patient's Signature or Patient's Representative Date

_____ _____

Printed Name of Patient's Representative Relationship to Patient

NOTE:
You have the right to know specifically what information you are authorizing for release (e.g. "results of a lab test performed on 1/4/03" or if your entire medical record is included "all health information").
You have a right to know the name(s) or other identification of the person(s) or organization authorized to release the information (e.g. the names of your health care provider(s)). You have the right to know who is going to use it and what is going to be used for (e.g. John Smith, PhD/Research)

You Have the Right to Receive A Copy Of This Form

HIPPA Authorization for Use / Disclosure of Protected Health Information. This form does not constitute legal advice and covers only Federal and not State laws.

Submit