Crystal Community E.N.T.
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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Updated September 2013

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been made aware that there is a copy of Crystal Community ENT's privacy practices available at the front desk containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its ***Notice of Privacy Practices*** from time to time and that I may contact the office to obtain a current copy of the ***Notice of Privacy Practices***.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, unless you are bound to abide by such restrictions.

COMMUNICATION PREFERENCES REGARDING PHI

To assist in your care, it may be necessary to release your ***Protected Health Information*** to someone other than yourself, another healthcare provider or your insurance company. To whom may we talk to?

Please list name and relationship:

1. _____
2. _____
3. _____
4. _____
5. _____

May we leave a message on:

- Your answering machine/voice mail at home □ Yes □ No □ N/A
- Your voice mail at work □ Yes □ No □ N/A
- Your voice mail on your cell phone □ Yes □ No □ N/A

Acknowledgement of receipt of Notice of Privacy Practice regarding protected health information

I have received the Practice's Notice of Privacy. Photocopies of this document are to be as valid as the original.

_____
Patient Name

_____ _____
Signature Date