Ear, Nose & Throat Associates of Mountain Home, PA

Notice of Privacy Practices Acknowledgement

We are required by law to maintain the privacy of, and provide individuals with, the notice of our legal duties and privacy practices with respect to protected health information (PHI). Please sign below to acknowledge that you have received a copy of our Notice of Privacy Practices.

_____ _____

Patient or Representative's Signature Date

Accounting of Disclosures of Protected Health Information

In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means.

I wish to be contacted in the following manner (check all that apply):

Home Telephone
- ☐ Ok to leave message with detailed information
- ☐ Leave call back number only

Work Telephone
- ☐ Ok to leave message with detailed information
- ☐ Leave call back number only

Message or emergency telephone
- ☐ Ok to leave message with detailed information
- ☐ Leave call back number only

Other_____
_____
_____

This would apply to answering machines or voice mail also.

_____ _____

Patient's Signature Date

_____ _____ _____

Signature of Patient's Representative Relationship to Patient Date

Dates covered by this Accounting Sheet: _____

The individual has the right to an accounting of disclosures made up to six (6) years prior to the date of the request

Date	Disclosed to: Name & Address or FAX	Description of Disclosure	Disclosure Basis	By

Patient's Name_____ Chart Number_____