

Otolaryngology
 Head and Neck
 Cancer
 Pediatric
 Otolaryngology
 Facial Plastic Surgery
 Allergy Management
 Balance Disorders
 Audiology

PATIENT ACKNOWLEDGMENT FORM
**Use & Disclosure of
 Protected Health Information**

Eastern Shore ENT & Allergy Association, P. A.'s "Notice of Privacy Practices" provides information about how we may use and disclose protected health information about you. Please acknowledge review and receipt, if requested, of this office's **Notice of Privacy Practices** by initialing below:

 Patient/Legal guardian

Our **Notice of Privacy Practices** states that we reserve the right to change the terms described. Should this happen, you will receive a revised copy, if requested, either by mail or at your next appointment.

 Patient/Legal guardian

You have the right to request restrictions 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/Legal guardian

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. Other than activities that have already occurred, you may revoke any further authorizations to use or disclose your health information.

Eastern Shore ENT & Allergy Associates, P.A. is authorized to discuss my medical health and treatment with:

 Name of Individual (if no one state "no one") Relationship

 Signature Patient/Legal guardian Date

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