

**ST. JOSEPH'S EAR, NOSE & THROAT CLINIC, PLLC**

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

I, [name of patient] \_\_\_\_\_, acknowledge and agree that I have received a copy of St. Joseph's Ear, Nose & Throat Clinic's Notice of Privacy Practices.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Legal Representative (if applicable)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Legal Representative

\_\_\_\_\_  
Relationship to patient

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**FOR CLINIC USE ONLY:**

**St. Joseph's Ear, Nose & Throat Clinic, PLLC** made the following good faith efforts to obtain the above-referenced individual's written acknowledgement of receipt of the Notice of Privacy Practices:

*[Identify the efforts that were made to obtain the individual's written acknowledgement, including the reasons (if known) why the written acknowledgement was not obtained.]*

**SIGNUP NOW!**

OUR CLINIC NOW HAS THE ABILITY TO COMMUNICATE WITH YOU BY SECURE EMAIL THROUGH NEXTMD. IF YOU ARE INTERESTED IN ENROLLMENT, PLEASE COMPLETE THE FOLLOWING:

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EMAIL ADDRESS

I ACKNOWLEDGE THAT I WILL NOT SHARE ACCESS OR USER NAME AND/OR PASSWORD.

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SIGNATURE

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DATE

