St Joseph's Ear, Nose, Throat & Allergy Clinic PLLC

ACKNOWLEGDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, DOB___/___/_____, acknowledge and agree that I have received a copy of St Joseph's Ear, Nose, Throat& Allergy Clinic's Notice of Privacy Practices. (HIPAA notice available at front desk upon request of the individual.)

_____ Date:_____

Patient signature

_____ Date:_____

Signature of Patient Legal representative (if applicable)

_____ _____

Printed Name of Patient Legal representative (if applicable) *Relationship to Patient*

For Clinic use only:

St Joseph's Ear, Nose, Throat & Allergy 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.]