

**ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE:**

I have been presented with a copy of ENT Surgical Associates of Central Georgia, P.C. **Notice of Privacy Policies**, detailing how my information may be used and disclosed as permitted under Federal and State law. I understand the Contents of the Notice, and I may request restriction(s) concerning the use of my personal medical information (PMI).

**Restriction(s) PLEASE LIST ANY INDIVIDUAL(s) THAT MAY NOT ACCESS PATIENT PMI:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Further, I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to medical assignment of benefits apply.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

\*\*\*If not signed by the patient, please indicate relationship to the patient (ie spouse, mother)\*\*\*

**Relationship to patient:** \_\_\_\_\_ **Witness:** \_\_\_\_\_

By initialing this each year your medical and demographic information continues to be used and disclosed as directed above and according to the Notice of Privacy Policy.

Initials: \_\_\_\_\_ Date: \_\_\_\_\_ Initials: \_\_\_\_\_ Date: \_\_\_\_\_

Initials: \_\_\_\_\_ Date: \_\_\_\_\_ Initials: \_\_\_\_\_ Date: \_\_\_\_\_

Initials: \_\_\_\_\_ Date: \_\_\_\_\_ Initials: \_\_\_\_\_ Date: \_\_\_\_\_

**INTERNAL USE ONLY:** If the patient or patient's representative refused to sign acknowledgement of receipt of notice, please document the date and time the notice was presented to the patient and sign below.

Presented on: \_\_\_\_\_ By whom: \_\_\_\_\_  
(date and time) (Employee name and title)

**FOR OFFICE USE ONLY:**

[ ] Consent received by: \_\_\_\_\_ Date: \_\_\_\_\_

[ ] Consent refused by patient and treatment refused as permitted.

[ ] Consent added to the patient's medical record on this date: \_\_\_\_\_