



ASHLAND  
ENT, ALLERGY &  
HEARING AID  
CENTER

# NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

In general, the HIPAA privacy rule allows an individual the right to request a restriction on the 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, such as sending correspondence to the individual's office or via fax instead of the individual's home.

**Patient's Name:** \_\_\_\_\_ **Acct#:** \_\_\_\_\_

**I wish to be contacted in the following manner (Check all that applies):**

<input type="checkbox"/> Home Telephone: _____	<input type="checkbox"/> Written Communications
<input type="checkbox"/> OK to leave a message with detailed information	<input type="checkbox"/> OK to mail to my home address
<input type="checkbox"/> Leave Message with call-back number	<input type="checkbox"/> OK to mail to my work address
<input type="checkbox"/> Work Telephone: _____	<input type="checkbox"/> Other: _____
<input type="checkbox"/> OK to leave message with detailed information	_____
<input type="checkbox"/> Leave Message with call-back number	_____

**Please list below the name(s) of individual(s) you authorized our office to discuss your Personal Health Information (PHI) with including all physicians:**

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

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_