ALAMO ENT ASSOCIATES

New Patient ________ Yearly Update ________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I ____ acknowledge that I have received a copy of
(Name of Patient)
Alamo ENT Associates' Notice of Privacy Practices. This notice describes how Alamo ENT Associates may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information. ________
(Initials)

HIPAA AUTHORIZATION FOR A RELEASE OF INFORMATION

I hereby authorize Alamo ENT Associates to release health information to:

___________________________________ ___________________________________
Full Name Relationship Full Name Relationship

___________________________________ ___________________________________
Full Name Relationship Full Name Relationship

HIPAA AUTHORIZATION TO TREAT MINOR FAMILY MEMBERS

I hereby authorize Alamo ENT Associates' providers to treat my minor child(ren) in the event I am unable to accompany him/her/them. The following people have my permission to bring my minor child(ren) in to Alamo ENT Associates:

___________________________________ ___________________________________
Full Name Relationship Full Name Relationship

SIGNED ____ **DATE** _______________
Patient/Parent's or Legal Guardian Full Signature