Michigan Otolaryngology Surgery Associates
Acknowledgment of Receipt of Notice of Privacy Practices

I acknowledge that I have received a copy of Michigan Otolaryngology Surgery Associates, and MOSA Audiology's Notice of Privacy Practices and Financial Policy.

Patient Name: _____

Authorization to discuss my medical record with other people:

In order for our office to be authorized to discuss any treatment and business (billing) issues in person and /or over the phone on my behalf, that person MUST be listed below:
If patient is a minor, parent(s) or guardian(s) should also be listed below.

NAME OF PERSON: _____

Relationship to Patient_____

NAME OF PERSON: _____

Relationship to Patient_____

NAME OF PERSON: _____

Relationship to Patient_____

NAME OF PERSON: _____

Relationship to Patient_____

Health information that is NOT to be released or discussed with ANYONE other than the above patient, or the accompanying parent/legal guardian, please initial below:

Initial Here:_____

Patient Signature: _____ Date: _____

Parent/Legal guardian of a minor patient

Signature: _____ Date: _____

This form should be updated (initial and re-dated) every year to remain valid, unless revoked in writing by the above patient or responsible parent or legal guardian.

MOSA Representative/Witness_____