Michigan Otolaryngology Surgery Associates

Acknowledgment of Receipt of Notice of Privacy Practices

I acknowledge that I received a copy of Michigan Otolaryngology Surgery Associates Notice of Privacy Practices and Financial Policy.

Print patient name: ____

Patient Signature: _______________________________________ Date: ________________

Parent or Legal Guardian of a Minor child/patient ___________________________________

Date____

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Authorization to discuss my medical record with other people:

In order for MOSA 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:

NAME OF PERSON: ____

Relationship to Patient____

NAME OF PERSON: ____

Relationship to Patient____

NAME OF PERSON: ____

Relationship to Patient____

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Health information that is NOT to be released or discussed with ANYONE should be described here: ____

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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____