

**SOUTH FLORIDA ENT ASSOCIATES, P.A.**  
**Care Center \_\_\_\_\_**

**Patient Acknowledgement of Receipt of the Notice of Privacy Practices  
and  
Consent to Use and Disclose Health Information**

I acknowledge that I was provided with a copy of the South Florida ENT Associates, P.A.'s Notice of Privacy Practices, describing how my health information may be used or disclosed under the federal law. Provided that South Florida ENT Associates, P.A. continues to its good faith effort to comply with the requirements of the federal privacy law, I hereby consent to the use and disclosure of my Health Information for the purposes and the activities permitted under the federal privacy law.

I understand that I should read the Notice of Privacy Practices carefully. I am aware that the Notice may be changed at any time. I may obtain a revised copy by calling the South Florida ENT Associates, P.A Corporate office at (305) 558-3724.

I acknowledge that I have received a copy of the South Florida ENT Associates, P.A. Notice of Privacy Practices.

\_\_\_\_\_  
Patient Name \_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Patient Legal Representative (if applicable) \_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Legal Representative

\_\_\_\_\_  
**FOR PHYSICIAN'S OFFICE USE ONLY**

\_\_\_\_\_  
**Office Staff Member Obtaining Signature**

**Reason Signature and Date were not obtained**

- Individual Refused to Sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please specify)

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