Dayton Head & Neck Surgeons, Inc.

PRIVACY PRACTICES & DESIGNATED INDIVIDUALS AUTHORIZATION FORM

I hereby authorize one or all of the designated parties below to request and receive the release of any protected health information regarding my treatment, payment, or administrative operations related to treatment and payment. I understand that the identity of designated parties must be verified before the release of any information.

Authorized designees:

Name:_____ Relationship:_____

Name:_____ Relationship:_____

(See other side) ▸ ▸ ▸

Dayton Head & Neck Surgeons, Inc.

PRIVACY PRACTICES ACKNOWLEDGMENT

Our Commitment to your Privacy:

Our organization is dedicated to maintaining the privacy of your identifiable health information. In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and privacy practices concerning your identifiable health information. By law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

I have received the Notice of Privacy Practices and have been provided an opportunity to review it.

Signature_____ Date _____