An affiliate of Penn Medicine
Ear, Nose and Throat Network

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE

I acknowledge that I received the NOTICE OF PRIVACY PRACTICES for:

Pinnacle ENT Associates, LLC

Name of Patient: _____

Date of Receipt: _____

Signature of Patient: _____
(Or patient's personal representative, parent or guardian)

Personal representative, parent or guardian information (if applicable):

Name: _____

Relationship to patient (or other authority) _____

I hereby authorize you to discuss or release any of my information to the following: (such as spouse, parent, and/or family member)

Name	**Relationship**
_____	_____
_____	_____
_____	_____

Signature of Patient or Personal Representative: _____