Patient:				
	Last Name	First Name	M. I.	Medical Record #
Birth Date:		Social Security #:		

Ear, Nose & Throat Associates of Charleston, Inc.
Acknowledgment of Receipt of Notice of Privacy Practices

In general, any information that is about your health, the health care you receive, or payment for that care is considered confidential and protected by our practice. We may need to use your protected health information to carry out treatment, payment, healthcare operations and/or other purposes. Our *Notice of Privacy Practices* provides a more complete description of permitted uses and disclosures.

Sign below to acknowledge that you have received a copy of our *Notice of Privacy Practices.*

X_____

X_____

Signature of patient or patient's representative *Date*

_____ _____

Printed name of patient or patient's representative *Relationship to the patient*

Please return this acknowledgment as soon as possible. If you received this form when you arrived at our practice for service, return this form in person before you leave. If you do not return the form in person, you may return this form by mail to our Privacy Officer at the following address:

Ear, Nose & Throat Associates of Charleston, Inc.
500 Donnally Street, Suite 200
P.O. Box 1628
Charleston, WV 25326-1628

For use ONLY by EN&T's representative:

A good faith effort was made to obtain a written acknowledgment of receipt of our *Notice of Privacy Practices* that was provided to (circle one) the patient/the patient's representative on _ _/_ _/_ _ _ _.

The acknowledgment was not obtained for the following reason(s): _____
_____
_____
_____

Signature of representative: _____