

**EAR NOSE AND THROAT ASSOICATES  
2340 KNOB CREEK ROAD, SUITE 704  
JOHNSON CITY, TN 37604  
423-929-9101**

WE ARE REQUIRED BY LAW TO MAINTAIN THE PRIVACY OF, AND PROVIDE INDIVIDUALS WITH THIS NOTICE OF OUR LEGAL DUTIES AND PRIVACY PRACTICES WITH RESPECT TO PROTECTED HEALTH INSURANCE. IF YOU HAVE ANY OBJECTIONS TO THIS FORM PLEASE ASK TO SPEAK WITH OUR **HIPPA** COMPLIANCE OFFICER IN PERSON OR BY PHONE AT 423-929-9101.

**SIGNATURE BELOW IS ONLY ACKNOWLEDGEMENT THAT YOU RECEIVED THIS NOTICE OF OUR PRIVACY PRACTICES:**

**PRINT NAME** \_\_\_\_\_ **DATE** \_\_\_\_\_

**PATIENT OR GUARDIAN SIGNATURE** \_\_\_\_\_

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**IF YOU WOULD LIKE TO REQUEST THAT EAR, NOSE AND THROAT ASSOCIATES, PC RELEASE YOUR PROTECTED HEALTH INFORMATION ONLY TO CERTAIN INDIVIDUALS, PLEASE LIST THOSE INDIVIDUALS BELOW:**

I \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

AUTHORIZE EAR, NOSE AND THROAT ASSOCIATES, PC TO GIVE MY **M E D I C A L** OR **F I N A N C I A L** — INFORMATION TO:

**PERSON** \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_  
PHONE NUMBER \_\_\_\_\_

**PERSON** \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_  
PHONE NUMBER \_\_\_\_\_

**PERSON** \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_  
PHONE NUMBER \_\_\_\_\_

IT IS THE PATIENT'S RESPONSIBILITY TO NOTIFY EAR, NOSE AND THROAT **ASSOCIATES.PC** OF ANY CHANGES AND SIGN A NEW FORM.

**PATIENT RIGHTS**

I UNDERSTAND THAT MY TREATMENT WILL NOT BE CONDITIONED ON SIGNING THIS AUTHORIZATION AND THAT I HAVE THE RIGHT TO REFUSE TO SIGN THIS AUTHORIZATION. I UNDERSTAND THAT INFORMATION DISCLOSED AS A RESULT OF **THIS** AUTHORIZATION MAY BE SUBJECT TO REDISCLOSURE BY **THE** RECIPIENT AND MAY NO LONGER BE PROTECTED BY FEDERAL OR STATE LAW.

I UNDERSTAND THAT I HAVE THE RIGHT TO REVOKE THIS AUTHORIZATION BY SENDING A WRITTEN NOTIFICATION TO THE ADDRESS ABOVE AND THAT A REVOCATION IS NOT EFFECTIVE IF THE INFORMATON HAS ALREADY BEEN DISCLOSED BUT WILL BE EFFECTIVE GOING FORWARD.

**I UNDERSTAND THAT I HAVE THE RIGHT TO INSPECT OR COPY THE PROTECTED HEALTH INFORMATION AS DESCRIBED IN THIS DOCUMENT. I CAN DO THIS BY WRITTEN NOTIFICATION TO EAR NOSE AND THROAT ASSOCIATES, PC.**

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**PATIENT OR GUARDIAN SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_