BELLEVUE EAR, NOSE AND THROAT
Notice of Privacy Practices –Acknowledgement

-We keep a record of the health care services we provide you. You may ask to see or receive a copy of that record, and may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting the Privacy Officer at 425-454-3938.
-Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, and how you can access your information. You may request a complete copy of our **Notice to Privacy Practices** or access this document on our website at www.bellevueent.com

By my signatures below I acknowledge access to Notice of Privacy Practices.

_____ _____
Signature of patient or authorized representative Date

_____ _____
Printed Name Relationship (parent, legal guardian, personal representative, etc.)

CONSENT TO LEAVE MESSAGES

I,_____give Bellevue Ear, Nose, and Throat permission to:
Printed Name

	Please Circle	
Leave a message regarding my upcoming office visit, account information, and/or test results on my answering machine.	**YES**	**NO**
Leave a message with someone who may answer the phone at my residence.	**YES**	**NO**
Leave a message at my place of employment.	**YES**	**NO**

_____
Signature

I authorize Bellevue ENT to disclose information and or review my care with:

_____
Name Relationship

Important please provide us with Name & Number of Preferred Pharmacy

_____ _____
Pharmacy Name Pharmacy Number

_____
Signature **(This form will be retained in your medical record)**