

BENKE EAR NOSE & THROAT CLINIC, P.A.

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

The law requires that Benke Ear, Nose & Throat Clinic, P. A. make every effort to inform you of your rights related to your personal health information. By signing below, I acknowledge that:

- I would like a personal copy of the Benke ENT Clinic’s Notice of Privacy Practices to have for my records.
- I do not wish to receive a personal copy of Benke ENT Clinic’s Notice of Privacy Practices.
- The Notice of Privacy Practice’s could not be read due to the emergent nature of the care described as:

I HAVE READ AND UNDERSTAND THIS FORM AND AM SIGNING VOLUNTARILY.

<hr/> Patient	<hr/> Date
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If you are signing as a personal representative of the patient, please indicate your relationship.

<hr/> Representative	<hr/> Relationship to Patient
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RELEASE OF MEDICAL INFORMATION

I, _____, authorize BENKE EAR NOSE & THROAT CLINIC, P. A. to release information regarding my medical care to the following persons

<hr/> Name	<hr/> Relationship
<hr/> Name	<hr/> Relationship
<hr/> Name	<hr/> Relationship
This document shall expire on:	<hr/> Date
<hr/> Patient	<hr/> Date