I acknowledge that I was provided with the Notice of Privacy Practices of the Ear, Nose, and Throat Associates at 348 Budfield Street, Johnstown, PA 15904.

Patient Signature:_____ Date:_____
Print Name:_____

In accordance with the confidentiality policy of Ear, Nose & Throat Associates of Johnstown, inc. and the federal privacy rule under the Health Insurance Portability and Accountability Act (HIPAA), a patient's health information is protected as it relates to their past, present or future physical health. A patient's protected health information (PHI) will be held in strictest confidence at all times.

If you wish to permit ENT Associates to discuss your protected health information with any other individual/individuals, please initial and list these individuals below.

_____ I permit ENT Associates to disclose and discuss my protected health information to the following individuals.

	NAME	RELATIONSHIP	PHONE
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____