

**METRO ENT & FACIAL PLASTIC SURGERY**

**a division of Centers for ENT Care, LLC**

**Annette M. Pham, M.D. ~ Andrew Y. Lee, M.D.**

**PRIVACY PRACTICES ACKNOWLEDGEMENT  
AND CONSENT FORM**

◆ I have received your Notice of Privacy Practices and/or I have been provided an opportunity to review it.

◆ I agree that telephone messages regarding my appointments, prescription renewals, lab results, and all other Protected Health Information\* ("PHI"), may be left for me on voicemail systems and answering machines at the following telephone numbers, in addition to any other numbers provided to you by me:

( ___ ___ ) ___ ___ - ___ ___	Home / Office / Cell / Other: _____
( ___ ___ ) ___ ___ - ___ ___	Home / Office / Cell / Other: _____
( ___ ___ ) ___ ___ - ___ ___	Home / Office / Cell / Other: _____

*[If we need to contact you with lab results, please place a check mark next to the preferred contact number, if any.]*

◆ I agree that my PHI may be shared with my spouse.  Yes  No

◆ I agree that my PHI may be shared with the following other people:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

◆ I understand that I can change any of the foregoing agreements, at any time, by giving written notice to Metro ENT & Facial Plastic Surgery.

*\*as defined in the Health Insurance Portability and Accountability Act of 1996 and its regulations, as may be amended from time-to-time ("HIPAA")*

Patient Name (print): \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If the patient is a minor (under 18 years of age), the responsible parent or guardian must sign above, and fill in the information below.

Parent/Guardian Name (print): \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_