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ACKNOWLEDGEMENT

PATIENT NAME: _____

I acknowledge that a copy of the Notice of Privacy Practices for ENT and Allergy Specialists was made available to me. If I wish to allow a family member or friend to receive my personal protected health information, I must sign an Authorization Form provided by the Practice.

Date: _____ **Patient Signature:** _____
(Patient-18 years of age or older, if under age parent or guardian signature)

Witness Signature: _____

AUTHORIZATION TO VIEW PRESCRIPTION HISTORY FROM EXTERNAL SOURCES

PATIENT'S OR AUTHORIZED PERSON'S CONSENT:

YOU HAVE MY PERMISSION TO VIEW PRESCRIPTION HISTORY FROM EXTERNAL SOURCES FOR THE FOLLOWING:

PATIENT NAME: _____ **DOB:** _____

RELATIONSHIP TO THE PATIENT CIRCLE ONE

SELF **PARENT** **OTHER:** _____

SIGNATURE: _____ **DATE** _____
(Patient-18 years of age or older, if under age parent or guardian signature)

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