MT SCOTT EAR, NOSE AND THROAT, & SLEEP MEDICINE

Robert L Roberts, DO James Chan, MD
Hillary Lowenstein, MD

Acknowledgement of Patient Policies for Mt Scott ENT and Sleep Medicine.

Thank you for understanding our policies. Please, let us know if you have any questions.

By signing you acknowledge having read, understood and agree to abide by these guidelines.

_____ _____
Signature of Patient or Responsible Party Date

Acknowledgement of Receipt of Privacy Policy

The 'Notice of Privacy Policy' tells you how we may disclose your personal health information. Not all situations will be described in the 'Notice of Privacy Policy.' We are required to give you this 'Notice of Privacy Policy' pursuant to the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and regulations promulgated there under.

I, _____ acknowledge that I have been provided a copy of, have read and understand the Notice of Privacy Policy for *Eastmoreland Ear, Nose, and Throat Clinic, LLP; Mt Scott Ear, Nose and Throat and Sleep Medicine; Dr. Robert Roberts; Dr. James Chan; Hillary Lowenstein, MD, Jeffrey Cox, MS, F/AAA* (the "Covered Entities") containing a complete description of my rights, and the permitted uses and disclosures under HIPAA.

While the Covered Entities have reserved the right to change the terms of the Notice of Privacy Policy copies of the Policy as amended are available from the Covered Entities at any of their offices or by sending a written request with return address to: Privacy Officer, Eastmoreland ENT, 9280 SE Sunnybrook Blvd. Suite 300 Clackamas, OR 97015

_____ _____
Signature of Patient or Patient Representative Date
(form must be completed before signing)

Printed name of patient:_____

Printed name of patient representative:_____

Relationship to patient:_____

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