# FLORIDA EAR NOSE THROAT
## AND FACIAL PLASTIC SURGERY CENTER
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## Acknowledgement of Notice of Privacy Practice

I hereby acknowledge that I have read the Florida Ear Nose Throat & Facial Plastic Surgery's Notice of Privacy Practices.

Name of Patient (Please Print): _____

Date of Birth: _____

Signature of patient or patient representative: _____

Date: _____

I authorize the release of health information including medical diagnosis, records, imaging report and discs, laboratory results, examination rendered to me and claims information to the following:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Signature of patient or patient representative: _____

Date: _____


**Diplomate, American Board of Otolaryngology** **Diplomate, American Board of Facial Plastic Surgery**
Fellow, American College of Surgeons Fellow, American Academy of Otolaryngology - Head and Neck Surgery
Fellow, American Rhinologic Society Fellow, American Academy of Cosmetic Surgery
Fellow, American Academy of Facial Plastic and Reconstructive Surgery