**Acknowledgement of Review of Notice of Privacy Practices
And Marketing Option Selection**

Hampton Roads Otolaryngology Associates, PLLC.

Patient Name:______________________ Chart #:____________________

I have reviewed the Notice of Privacy Practices for this practice and received a copy for my records, if requested. I consent to release of my Protected Health Information for the purposes of treatment, payment, and healthcare operations (as defined in the Notice). I understand that any release of information beyond these three purposes or any other legally permitted release requires a separate authorization.

______________________________ ______________________________ ____________________
Patient/Parent/Guardian Name (print) Patient/Parent/Guardian Signature Date

We must allow you the opportunity to opt-out of receiving information from our practice regarding treatment options available to you and other services we offer now and in the future. We will never release your information to a third party outside the scope of our Privacy Practices as explained on the Notice. If you do not make a selection and sign below, we will assume that you have consented to receive this information from us. Please make a selection below:

Yes, I would like to receive information regarding treatment options and other services provided by Hampton Roads Otolaryngology Associates, PLLC.

No, I do not want information regarding treatment options and other services provided by Hampton Roads Otolaryngology Associates, PLLC.

______________________________ ______________________________ ____________________
Patient/Parent/Guardian Name (Print) Patient/Parent Guardian Signature Date

Authorization for Release of Medical Information

I, ________________________, (patient's name) hereby authorize Hampton Roads Otolaryngology Associates, PLLC to release or discuss any of my medical information with the follow individuals: (We cannot discuss any medical information with other physicians unless noted on your patient information form or listed here)

Name	**Relationship to Patient**

If you would like to set limitations on what medical information can be released to these individuals please list below what information we may provide. If you would like no limitations set then just write ALL.

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*Please note that this authorization will expire in 1 year. If you would like to set a particular expiration date for less than 1 year please specify:___________________

Patient/Parent/Guardian Signature___________________________ Date:______________________

If not Patient, relationship to patient:_________________________