# Acknowledgement of Receipt of HIPAA Notice of Privacy Practices

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, on our website, and that a copy of any amended Notice of Privacy Practices will be available at each appointment.

This office strictly prohibits electronic recording or videotaping of any kind in consideration of the privacy and confidentiality of the physician-patient relationship. We sincerely appreciate your compliance with our request.

---

☐ I would like to receive a copy of any amended Notice of Privacy Practices by e-mail at:

________________________________________

**Signed:** __________________________ **Date:** __________________________

**Print Name:** _______________________ **Telephone:** _______________________

---

If not signed by the patient, please indicate relationship:

☐ Parent or Guardian of minor patient

☐ Guardian or conservator of an incompetent patient

☐ Beneficiary or personal representative of deceased patient

Name of Patient: __________________________________________________

Address of Patient: ________________________________________________

Pacific ENT Medical Group, Inc.

6010 Hidden Valley Rd., Suite 210

Carlsbad, CA 92011

Privacy Officer: Jennifer Putman

Ph. 858-755-9343