

I have been provided with a Notice of Privacy Practices, in compliance with HIPAA (Health Insurance Portability & Accountability Act) regulations.

I have read and understand my rights under HIPAA as provided to me by Feldman Oringher Dettelbach Mesick Schoenfeld Otolaryngology, P.C.

I authorize Feldman Oringher Dettelbach Mesick Schoenfeld Otolaryngology, P.C. to contact me for the following reasons:

- Permission to call me at my home, office, or mobile to confirm or reschedule an appointment, to provide me with test results, or to return my message(s).
- Permission to leave appointment reminders or appointment cancellation notifications on an answering machine, or with a family member, secretary, or household employee
- Permission to mail reminder postcards regarding appointments
- Permission to leave “your test results were normal” on an answering machine

These services are provided as a courtesy by our practice. I understand that by giving my permission for the above services, I have in no way authorized the release of any confidential medical information.

Patient Name: _____

Signature: _____

Date: _____

Witness: _____