MID-KANSAS EAR, NOSE & THROAT
DIVISION OF WICHITA SURGICAL SPECIALISTS, P.A.

ACKNOWLDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND MEANS OF COMMUNICATION FOR PROTECTED HEALTH INFORMATION

PATIENT NAME: ______________________________ **DOB:** ______________

I acknowledge that I have received a copy of Mid Kansas Ear, Nose & Throat, Division of Wichita Surgical Specialists, P.A.'s Notice of Privacy Practices with the effective date of 04/01/2003. (Revised 12/07/2015)

HOW MAY WE CONTACT YOU?

(PLEASE CHECK ALL THAT APPLY)

**** PLEASE NOTE: UNLESS NOTED BELOW, WE CAN SPEAK ONLY TO THE PATIENT OR LEGAL GUARDIAN REGARDING APPOINTMENTS, TEST RESULTS, ETC. ****

____ **Home Phone & Answering Machine**

____ **Work Phone & Voice Mail**

____ **Cell Phone & Voice Mail**

____ **Spouse**

____ **Parents**

____ **Other (list name)** ______________________________

______________________________ ______________________________
Signature of Patient/Patient Representative Date

____
Relationship to Patient

FOR WICHITA SURGICAL SPECIALISTS, P.A. USE ONLY

Signature of Privacy Official: ______________________________ Date: ______________