Otolaryngology Physicians Of Lancaster
Board Certified Ear, Nose and Throat Specialists

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Ephrata, PA 17522
Office 717-733-4891
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Acknowledgement of Receipt of Privacy Practices

Patient's Name: _____ has received a copy of OPL's Notice of Privacy Practices.

_____ _____
Patient Signature Date

Please use the section below if you are signing on behalf of a minor or as a legal guardian

_____ _____
Parent/Legal Guardian Signature Date

_____ _____
Parent/Legal Guardian Print Date

Patient Authorization for Use and Disclosure of Protected Health Information

I wish to be contacted at the following number: _____

OPL has my permission to leave a detailed message concerning appointments or other details of my medical care at this number ☐ Yes ☐ No

I grant permission for OPL to discuss/release medical and billing information to the following person(s):

Name: _____ Name: _____
Telephone: _____ Telephone: _____
Relationship: _____ Relationship: _____

HIPAA (Health Insurance Portability Accountability Act) privacy rules give you the right to request a restriction of your protected health information (PHI). When PHI is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA privacy rule.

_____ _____
Patient Signature Date

Please use the section below if you are signing on behalf of a minor or as a legal guardian

_____ _____
Parent/Legal Guardian Signature Date

_____ _____
Parent/Legal Guardian Print Date