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## ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE

I have been advised of Desert Ear, Nose & Throat Medical Group, Inc., **Notice of Privacy Policies**, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following restriction(s) concerning the use of my personal medical information (if any, please state):

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Please Initial:

\_\_\_\_\_ I give permission

\_\_\_\_\_ I decline my permission

For Desert Ear, Nose & Throat Medical Group, Inc. to call my home or leave a message on a machine, or to speak to anyone other than my self, (Please state name): \_\_\_\_\_ to confirm appointments and/or to convey pertinent health information.

\_\_\_\_\_  
(signature)

\_\_\_\_\_  
(Date)

If not signed by patient, please indicate relationship to patient (e.g., spouse, parent)

\_\_\_\_\_  
(relationship to patient)

\_\_\_\_\_  
(witness)

### **INTERNAL USE ONLY:**

If patient or patients' representative refuses to sign acknowledgment of receipt of notice, please document the date and time the notice was presented to patient and sign below.

Presented on (date and time): \_\_\_\_\_ By (name & title): \_\_\_\_\_