

Front Range Otolaryngology & Facial Plastic Surgery, P.C.

Name of Patient (please print)

Date of Birth

Acknowledgment of Notice of Privacy Practices

I hereby acknowledge that I received Front Range Otolaryngology and Facial Plastic Surgery’s Notice of Privacy Practices. (Please read below)

Signature of Patient or Patient Representative

Date Signed

Documentation of Good Faith Efforts
To Obtain patient’s acknowledgment that they received provider’s Notice of Privacy Practices

(For use when acknowledgment cannot be obtained from the patient)

____/____/____

The patient presented to the office on (insert date) and was provided with a copy of FROFPS’s Notice of Privacy Practices. A good faith effort was made to obtain from the patient a written acknowledgment of his/her receipt of the Notice. However, such acknowledgement was not obtained because:

- Patient refused to sign.
- Patient was unable to sign or initial because: _____
- The patient had a medical emergency, and an attempt to obtain the acknowledgement will be made at the next available opportunity
- Other reason _____

Employee Signature

Date

NOTICE OF PATIENT INFORMATION PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO INFORMATION. PLEASE REVIEW IT CAREFULLY.

Front Range Otolaryngology and Facial Plastic Surgery’s LEGAL DUTY

FROFPS is required by law to protect the privacy of your personal health information, provide notice about our information practices and follow the information practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

FROFPS uses your personal health information primarily for treatment; obtaining payment for treatment; conducting internal administrative activities and evaluating the quality of care that we provide. For example; FROFPS may use your personal information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you.

FROFPS may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, for research studies and for emergencies. We also provide information when required by law.

In any other situation, FROFPS’s policy is to obtain your written authorization before disclosing your personal health information. If you provide us with written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

PATIENTS’S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment or other related administrative purposes.

You may also request in writing that we not use or disclose your personal health information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law or in emergency circumstances. FROFPS will consider all such request on a case by case basis, but the practice is not legally required to accept them.

CONCERNS AND COMPLAINTS

If you are concerned that FROFPS may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our practice manager at 720-494-9111. You may also send a written complaint to the US Department of Health and Human Services. Complete Notice of Privacy Practices available upon request.