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**ACKNOWLEDGEMENT OF RECEIPT OF
INFORMATION**

I. NOTICE OF HEALTH INFORMATION PRACTICES ACKNOWLEDGEMENT

I understand that as part of my health care, Midwest ENT, LLC. will create and maintain health information that will be used for treatment, payment and health care operations.

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I have been given a copy of the Midwest ENT, LLC. "Notice of Health Information Practices" that provides a more complete description of information uses and disclosures. I understand that I have the right to review the Notice prior to signing this acknowledgement. I understand that Midwest ENT, LLC. reserves the right to change the Notice and its practices, and that I may obtain a copy of the revised Notice by request.

II. AUTHORIZATION TO RECEIVE MARKETING AND PUBLIC RELATIONS MATERIALS

Midwest ENT, LLC. and The Midwest Hearing Aid Center produce general health and safety information and other materials about goods and services that may be of interest to me. In order for me to receive this type of information, the Practice may access information (e.g. name, address) needed to provide me with these marketing and public relations materials. I understand that these materials are prepared to benefit Midwest ENT, LLC.

[] YES! I would like to receive marketing and public relations materials from Midwest ENT, LLC. And The Midwest Hearing Aid Center

[] NO, I do not want to receive any marketing or public relations materials from Midwest ENT, LLC. or The Midwest Hearing Aid Center

Print Patient's Name: _____

Signature of Patient, Parent, or Legal Guardian: _____

Date (month/day/year) _____