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**NORTHERN ORANGE COUNTY ENT MEDICAL CORP**

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**NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT**

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

**Our commitment to protecting health information about you**

In this Notice, we describe the ways that we may use and disclose health information about our patients. The HIPAA Privacy Rule requires that we protect the privacy of health information that identifies a patient, or where there is a reasonable basis to believe the information can be used to identify a patient. This information is called protected health information or PHI. This Notice describes your rights as our patient and our obligations regarding the use and disclosure of PHI. We are required by law to:

- Maintain the privacy of PHI about you;
- Give you this Notice of our legal duties and privacy practices with respect to PHI;
- Comply with the terms of our Notice Of Privacy Practices that is currently in effect.

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I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- \* Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly.
- \* Obtain payment from third-party payers.
- \* Conduct normal health care operations such as quality assessments and physician certifications.

I have read and understand your "Notice of Privacy Practices". If I desire a more complete description of the uses and disclosure of my health information, it can be provided. I understand that this organization has the right to change its "Notice of Privacy Practices" from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the "Notice of Privacy Practices".

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations.

I also understand that you are not required to agree to my requested restrictions as noted above (\*). However, if you do agree then you are bound to abide by such restrictions.

Patient or Guardian Name: \_\_\_\_\_

Patient or Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_