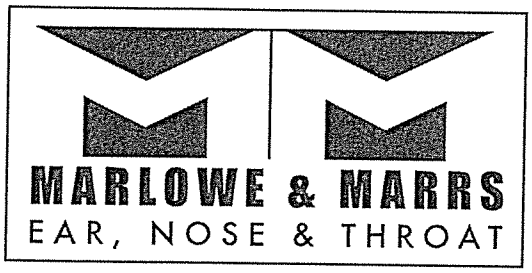

Notice of Privacy Practices Patient Acknowledgment

Effective 05/13/2014

Andrew Marlowe M.D. Ear Nose and Throat
5432 Bee Ridge Road Suite 150
Sarasota, Florida 34233

Patient Name: _____ **Date of Birth:** _____

By signing this form, you acknowledge receipt of the Notice of Privacy Practices from Andrew Marlowe M.D. Ear Nose and Throat. The Notice of Privacy Practices provides information about how he may use and disclose your protected health information. We encourage you to review it carefully. The Notice of Privacy Practices is subject to change. If the Notice is changed, you may obtain a revised copy by visiting our website at http://www.marlowemd.com/ or on request from our staff.

I acknowledge receipt of the Notice of Privacy Practices from Andrew Marlowe M.D.

Signature: _____

Relationship to Patient: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature of this Notice of Privacy Practices Form, but was unable to do so.

Date: _____ Name: _____

Reason: _____

_____