



MICHAEL H. BERTINO, M.D. G. PAUL LAURSEN, M.D., D.D.S., F.A.C.S. HARRY SCHILLING, M.D., F.A.C.S. STEPHEN J. TALLEY, M.D., F.A.C.S.

GILBERT M. RUIZ, M.D., F.A.C.S. ROBERT P. SPEARS, M.D., F.A.C.S. DIANA H. HENDERSON, M.D. PATRICK N. BROWN, M.D.

DEVANG P. DESAI, M.D., F.A.C.S. DANIEL J. FLEMING, M.D. RICHARD K. NEWMAN, M.D., F.A.C.S. NATHAN W. HALES, M.D.

**SAN ANTONIO HEAD & NECK SURGICAL ASSOCIATES, P.A. DBA**  
**Ear, Nose & Throat Clinics of San Antonio, P.A.**

## Acknowledgement of Review of Notice of Privacy Practices and Red Flag Policy

I have reviewed and understand San Antonio Head & Neck Surgical Associates, P.A. dba Ear, Nose & Throat Clinics of San Antonio, P.A.'s Notice of Privacy Practices and Red Flag Policy, which explains how my medical information will be used and disclosed and how I can get access to my medical information. I know that I may have a copy of the Notice. I also know that from time to time, the Notice of Privacy Practices and Red Flag Policy may be revised. If I want the revised Notice of Privacy Practices and Red Flag Policy, I know I must ask for it.

I have also read and understand the Red Flag Policy and agree to provide the requested documentation of my identity. I understand that if I do not have documentation of my identity, I may be denied services until that documentation is provided.

You agree to allow us access to your medical information for the purpose of the research we are conducting, if you are eligible for said research, you agree or give permission to be contacted.

---

Signature of Patient or Personal Representative

---

Date

---

Name of Patient or Name (or Specific Identification)  
of authorized Personal Representative

---

Description of Personal Representative's Authority  
to Act for Patient