Pinnacle ENT ASSOCIATES LLC

CHESTER COUNTY OTOLARYNGOLOGY & ALLERGY ASSOCIATES DIVISION

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE

I acknowledge that I received the NOTICE OF PRIVACY PRACTICES for

PINNACLE ENT ASSOCIATES, LLC

CHESTER COUNTY OTOLARYNGOLOGY & ALLERGY ASSOCIATES DIVISION

Name of Patient: _____ DOB: _____

Date of Receipt: _____ Signature of Patient: _____

(or patient's personal representative, parent or guardian)

Personal representative, parent or guardian information (if applicable):

Name: _____

Relationship to Patient (or other authority): _____

I hereby authorize you to discuss or release any of my information to the following:

(such as spouse, parent, family member)

Name	**Relationship**
_____	_____
_____	_____
_____	_____

Signature of Patient or Personal Representative _____ Date _____

PENN MEDICINE AFFILIATION NOTICE

PATIENT DISCLAIMER AND ACKNOWLEDGEMENT

Pinnacle ENT Alliance, LLC, through its practice, ***Chester County Otolaryngology & Allergy Associates,*** is pleased to be affiliated with Penn Medicine and to participate in the Penn ENT Specialty Network. As part of the network, Pinnacle ENT Alliance, LLC is working with Penn Medicine to improve the quality of care provided to its patients.

Pinnacle ENT alliance, LLC, through its practice, ***Chester County Otolaryngology & Allergy Associates,*** is an independent physician practice group and is not owned by or a part of the University of Pennsylvania Health System. Neither the University of Pennsylvania Health System nor the Hospital of the University of Pennsylvania dictates or directs the manner in which care is provided by Chester County Otolaryngology & Allergy Associates. Each physician affiliated with ***Chester County Otolaryngology & Allergy Associates*** exercises independent medical judgement in the care of his or her patients.

If you have any questions about the relationship that Pinnacle ENT alliance, LLC or ***Chester County Otolaryngology & Allergy Associates*** has with Penn Medicine, please ask your physician.

Please sign below to indicate that you have read this acknowledgement and have had an opportunity to ask questions.

Signature of Patient or Personal Representative _____ Date _____