

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: _____

Date of Birth: _____

Address: _____

City/State/Zip _____

Social Security #: _____

Phone #: _____

I acknowledge that I received a copy of The Hearing Care Clinic's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, the website (if applicable) and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

- This Notice informs me how The Hearing Care Clinic will use my health information for the purposes of my treatment and/or payment for my treatment.
- This Notice explains in more detail how The Hearing Care Clinic may use and share my health information for other than treatment, payment, and health care operations.
- The Hearing Care Clinic will also use and share my health information as required/permitted by law.

Printed name of patient or personal representative

Date

Signature of patient or personal representative

Date