

The Hearing Center

HIPAA PRIVACY RECEIPT ACKNOWLEDGEMENT

The Hearing Center Notice of Privacy Practices has been provided to me if I request it. I understand by signing this document, **I acknowledge The Hearing Center's Notice of Privacy Practices.**

The Notice of Privacy Practices for The Hearing Center is also provided at the front desk of The Hearing Center offices and on The Hearing Center's web site at www.hearingclinics.com.

The Hearing Center reserves the right to change the privacy practices that are described in the Notice of Privacy Practices.

I may obtain a revised notice of privacy practices by accessing The Hearing Center's web site, calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Patient's Name:

Patient's Date of Birth:

X _____ **Date: X** _____
Signature of Patient or Personal Representative

Description of Personal Representative's Authority (parent, guardian, etc.)

I authorize the following individuals to have minimal access to my personal health information – appointment and scheduling information, billing records (this does not include copies of medical records):

Name	Relationship
_____	_____
_____	_____
_____	_____
_____	_____