

PRIVACY ACKNOWLEDGEMENT

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name: _____

Signature: _____

Date: _____

The privacy Rule portion of the HIPAA regulations requires our practice to submit a copy of the Privacy Notice to each patient, both existing and new. If the patient refuses to sign the notice, the practice is not obligated to treat the patient.

REQUEST FOR RELEASE OF INFORMATION

I authorize Associates in hearing HealthCare to release information to the following:

Doctor / Practice / Child Study Team	1)	2)	3)
Address			
City, State, Zip			
Phone			

Name: _____

Signature: _____

Date: _____