Acknowledgement of Receipt of Notice of Privacy Practices - HIPAA

The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations. This acknowledgement of notice and consent authorizes Home Hearing Aid Care, LLC to use health information about you ONLY for the purposes of treatment, payment, and health care purposes.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations.
By signing this form, you consent to our use and disclosure of your protected healthcare information appropriately and by complying with the law.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES NO

May we leave a message at home or on your cell phone? YES NO

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed: _____

_____

This consent was signed by: _____
(PRINT NAME PLEASE)

Signature: _____Date: _____

Witness: _____Date: _____