Privacy Practices Acknowledgement

Patient Name _____

Please fill out the following information and sign and date the bottom

The Hearing Center **MAY** leave private health information, on an answering machine or voice mail, regarding the above named patient.

Please list phone numbers where we may contact you or leave messages:

Home:_____

Work:_____

Cell:_____

List people or family members with whom we may leave private health information:

_____Relationship_____

_____Relationship_____

_____Relationship_____

I have been provided with an opportunity to review the Notice of Privacy Practices.

SIGNED_____DATE_____