Privacy Practices Acknowledgement

Patient Name:_____

Please fill out the following information sign and date below.

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:_____

EMAIL:_____

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

_____relationship_____

_____relationship_____

_____relationship_____

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

Signed_____ Date_____