AMERICAN HEARING CENTER

WE LISTEN SO YOU CAN HEAR

ACKNOWLEDGEMENT FORM

Date: ______________________

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

Name _______________________________________ Signature _______________________________________

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, this practice is not obligated to treat the patient.

By signing this paper below, I give permission to the person(s) listed in the table documented to receive limited information about my care. I understand my healthcare provider will use their professional judgment to ensure that information is shared with my family/friend in order to assist with my continuing care. Any information requested that does not pertain to assisting with my health care and any requests for copies of medical records will require a signed HIPPA compliant authorization. This permission will be considered ongoing until I state in writing otherwise.

Date of Permission	Name of Individual & Relationship to Patient	Comments/Instructions (i.e.: may disclose test results, hearing aid information, etc.)	Patient/Guardian Initials

I give permission for my information to be sent to my referring provider: ____**Yes** | ____ **No**

American Hearing Center HAS MY PERMISSION TO: (Please check all boxes that apply)

☐ Leave a message at home with my spouse **or**:

Name:____ Relationship:_________________________________

☐ Leave a detailed message on my answering machine. Home Cell Work

☐ Email me. Email address: ____

Signature: ____

1618 Canyon Creek Dr. Ste. 140
Temple TX 76502
254.774.7727

1-800-234-4621
info@americanhearingcenter.com

2806 S. WS Young, Ste. C
Killeen, TX 76542
254.680.3444