ADVANCED AUDIOLOGY
NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more completed description of the uses and disclosures of my health information. I have been given the right to read and review such Notice of Privacy Practices prior to signing this consent. I understand that Advanced Audiology has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the office address to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that Advanced Audiology restrict how my protected health information is used or disclosed to carry out treatment, payment, or health care operations. I also understand that Advanced Audiology is not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

- ❑ I have read the Notice of Privacy Practices.
- ❑ I decline to read the Notice of Privacy Practices.

Date _____

Patient Name _____

Signature _____

Printed Name (If not patient) _____

Address _____
Street City State Zip

OFFICE USE ONLY

The patient is unable to read the Notice of Privacy Practice or sign the acknowledgement/consent form as documented below:

Date:	Initials:	Reason: