ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: ______________________________ Date of Birth: __________________

Address: __________________________________ City/State/Zip __________________

Social Security #: ___________________________ Phone #: ______________________

I acknowledge that I received a copy of Mt. Harrison Audiology and Hearing Aids LLC's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, the website (if applicable) and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

- This Notice informs me how Mt. Harrison Audiology and Hearing Aids LLC will use my health information for the purposes of my treatment and/or payment for my treatment.
- This Notice explains in more detail how Mt. Harrison Audiology and Hearing Aids LLC may use and share my health information for other than treatment, payment, and health care operations.
- Mt. Harrison Audiology and Hearing Aids LLC will also use and share my health information as required/permitted by law.

____ ____________________

Printed name of patient or personal representative Date

____ ____________________

Signature of patient or personal representative Date