Roseville Diagnostic Hearing Center, LLC

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent, I authorize Roseville Diagnostic Hearing Center, LLC to use and disclose my protected health information to carry out treatment (including direct or indirect treatment by other healthcare providers involved in my treatment). I authorize Roseville Diagnostic Hearing Center, LLC to obtain payment from third party payers and day to day healthcare operations of your practice.

I have received the Notice of Privacy Practices, been informed of, and given the right to review a copy of your Notice of Privacy Practices. I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use of disclosure that occurred prior to the date I revoke this consent is not affected.

Date:_____ **Patient Name**:_____

Signature (Patient/Representative):_____

If signed other than patient, print name and relationship"

Name:_____ **Relationship**:_____

Witnesses (2) only required for telephone request, physical inability to sign, or signature by mark:

Date:_____ **Witness**:_____ **Witness**: _____

INABILITY TO OBTAIN ACKNOWLEDGEMENT:

Complete only if signature cannot be obtained due to:

[ ] The patient is not able to sign the form and there is no legal representative available.

[ ] The patient refuses to sign the acknowledgement of receipt.

Date:_____ **Signature of Employee**:_____