aspen AUDIOLOGY

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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 health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal health care operations such as quality assessments and physician certifications.

I have received, read and understand the Notice of Privacy Practices document containing a more complete description of the uses and disclosures of my health information. I understand that Aspen 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 address below for a current copy of the Notice of Privacy Practices document.

_____ _____

Signature of Patient or Legally Authorized Representative | Date

_____ _____

Printed Name of Patient or Legally Authorized Representative | Date

Please list below the individual(s) with whom you authorize our office to discuss your care. Your PHI may be disclosed to the individual(s) below unless you notify us otherwise in writing.

_____ _____

Name/Relationship to Patient | Name/Relationship to Patient

_____ _____

Name/Relationship to Patient | Name/Relationship to Patient

FOR OFFICE USE ONLY

Practice provided the above-referenced patient with the Practice's Notice of Privacy Practices and this Acknowledgment of Receipt of Notice of Privacy Practices, but could not obtain a signed acknowledgment form because:

- ☐ The patient or guardian refused to sign.
- ☐ Due to an emergency situation, it was not possible to obtain an acknowledgment.
- ☐ Other (Please provide specific details) _____