Family Hearing Care

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

☐ By checking this box and signing below, I acknowledge that I received a copy of Family Hearing Care's Notice of Privacy Practices. The Notice provides information about how we may use and disclose the medical information that we maintain about you. We encourage you to read the full Notice. I understand that a copy of the current Notice will be posted in the reception area, the website (if applicable) and that any revised Notice of Privacy Practices will be made available.

_____

Printed Name of Patient or Personal Representative

_____ _____

Signature of Patient or Personal Representative **Date**

I Give permission for Family Hearing Care to leave a message regarding my hearing aids, and/or my appointments if I am not available.

_____ On my voicemail/answering machine.

_____ With the person answering the telephone.

Patient/Guardian Signature: _____

Date: _____