

HIPAA Acknowledgement of Receipt of Notice

Patient Name: _____ DOB: _____

I hereby acknowledge that I have read this medical practices notice of Privacy Practices.

Please check which one applies:

- ☐ I wish to receive a printed copy of Duncan-Nulph Hearing Associates Notice of Privacy Practices.
- ☐ I do not want a printed copy of Duncan-Nulph Hearing Associates Notice of Privacy Practices.

Patient or Representative Signature _____ Date _____

Name of Representative & Relationship to Patient (parent, guardian, POA, etc) _____

For Office Use Only:

- ☐ ***Patient / Representative refused to sign.***

Acknowledge refused by patient or representative: _____

Reason for refusal: _____

Staff Member: _____

Signature: _____ Date: _____