SHAWN LANCASTER, Au.D., CCC-A
608 E. Clark Blvd, Murfreesboro, TN 37130

Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights of 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 healthcare providers who may be involved in that treatment…directly and/or indirectly.
- Obtain payment from third-party payers (Insurance Companies).
- Conduct normal healthcare operations such as quality assessments and physical certifications.

I acknowledge that I have been offered a copy of your Notice of Privacy Practices, containing a more complete description of the use and disclosures of my health information. I understand that this organization has the right to change the Notices of Privacy Practices from time to time, and that I may contact this organization at any time, at the address above, to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

PATIENT NAME: _____

Relationship to Patient: _____

SIGNATURE: _____ DATE: _____

PLEASE LIST ANYONE WHO MAY CALL ON YOUR BEHALF SO THAT WE MAY SPEAK WITH THEM REGARDING YOUR MEDICAL INFORMATION AT THIS FACILITY:

Name: _____ phone #: _____

Relationship to patient: _____

Name: _____ phone #: _____

Relationship to patient: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below.

Date: _____ Initials: _____

Reason: _____