Acknowledgment of Receipt of Privacy Notice

Purpose of this Acknowledgment

This acknowledgment, which allows the Practice to use and/or disclose personally identifiable health information for treatment, payment or healthcare operations, is made pursuant to the requirements of 45 CFR §164.520(c)(2)(ii), part of the federal privacy regulations for the Health Insurance Privacy and Accountability Act of 1996 (the "Privacy Regulations").

Please read the following information carefully:

1. I understand and acknowledge that I am consenting to the use and/or disclosure of personally identifiable health information about me by Advanced Hearing Care, Alamogordo 88310 (the "Practice") for the purposes of treating me, obtaining payment for treatment of me, and as necessary in order to carry out any healthcare operations that are permitted in the Privacy Regulations.

2. I am aware that the Practice maintains a Privacy Notice that sets forth the types of uses and disclosures that the Practice is permitted to make under the Privacy Regulations and sets forth in detail the way in which the Practice will make such use and disclosure. By signing this Acknowledgment, I understand and acknowledge that I have received a copy of the Privacy Notice or that one is available upon my request.

I understand the foregoing provisions, and I wish to sign this Acknowledgment authorizing the use of my personally identifiable health information for the purposes of treatment, payment for treatment and healthcare operations.

Signature of Patient or Representative **Date**

Patient's Name

Date of Birth

Name of Personal Representative (if applicable) **Relationship to Patient**

Advanced HEARING CARE

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