ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: _____ Date of Birth: _____

Address: _____ City/State/Zip _____

Phone #: _____

I acknowledge that I have received a copy of North Suburban Hearing Service, Ltd.'s Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, the website (if applicable) and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

- **This Notice informs me how North Suburban Hearing Services, Ltd. will use my health information for the purposes of my treatment and/or payment for my treatment.**
- **This Notice explains in more detail how North Suburban Hearing Services, Ltd. may use and share my health information for other than treatment, payment, and health care operations.**
- **North Suburban Hearing Services, Ltd. will also use and share my health information as required/permitted by law.**

_____

Printed name of patient or personal representative

_____ _____

Signature of patient or personal representative **Date**

List below the individuals who may be included in your health care decisions

_____ _____

Name **Relationship to Patient**

_____ _____

Name **Relationship to Patient**

_____ _____

Name **Relationship to Patient**