Hearing Associates of Dothan, LLC

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Dothan, AL 36305
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HIPAA Acknowledgement Receipt

_____ **(initial here)** By initialing this section and signing below, I accept and acknowledge that I may request to receive a copy of Hearing Associates of Dothan, LLC's Notice of Privacy Practices. The Notice provides information about how we may use and disclose health information for the purposes of treatment and/or payment; purposes for other than treatment and health care operations; and shared as required/permitted by law. 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.

I acknowledge I was offered a copy of Hearing Associates of Dothan, LLC's notice of Privacy Practices. Please ***INITIAL*** *next to your choice:*

_____**No**, I do not wish to receive a copy of the office's Notice of Privacy Practices.

_____**Yes**, I would like to receive a copy of the office's Notice of Privacy Practices.

_____ (**initial here**) I authorize Hearing Associates of Dothan, LLC to notify me of appointments, hearing aids/material pickups and any other such information via home phone, cell phone, email or text the numbers/email address that I provide. I further agree that a message may be left at the home or cell phone numbers that I provide if I am not available. Hearing Associates will never use my information for marketing purposes outside of their offices.

_____ (**initial here**) I authorize Hearing Associates of Dothan to market/contact me regarding new services and/or treatment options that may further educate me regarding my hearing health.

Due to HIPAA regulations, please list any authorized person(s) with whom we may discuss your appointments, diagnosis, insurance and/or payments or who may be allowed to pick up hearing aids or materials for you from our office.

Name of Authorized Person(s): **Relationship to Patient:**

_____

_____

_____

Patient's Name (printed):_____ Date of Birth:_____

Signature:_____ Date:_____

(Responsible party signs if patient is a minor or is unable)