ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

Patient Name: _____ Patient Date of Birth:_____

I hereby acknowledge that I have been given the opportunity to review a copy of the Notice of Privacy Practices ("Notice") provided by Hearing Healthcare of Havasu. I further acknowledge that I have been advised that I may request a paper copy of that Notice for my records. I am aware that I have the option of reviewing it on the clinic's website at any time by visiting www.HavasuHearingHealthcare.com.

- I understand that the Notice is provided as required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
- The Notice describes how my health information, as a patient of Hearing Healthcare of Havasu, may be used and disclosed for the purpose of providing treatment and/or collecting payment for my treatment.
- The Notice also explains how my information may be used by Hearing Healthcare of Havasu for purposes other than treatment, payment, audiological/health care operations, as permitted/ required by law.

If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact Hearing Healthcare of Havasu, 1945 Mesquite Ave. Suite D, Lake Havasu City, Az 86403 at 928-732-0888. You will not be penalized for filing a complaint. After contacting us you will be asked to submit your complaint in writing.

Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice. If you have any questions regarding this notice or our health information privacy practices, please contact our office by phone at 928-732-0888.

_____ _____

Patient Name (or Personal Representative) Patient Signature (or Personal Representative)

_____ _____

Relationship to Patient Date