Patient #: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have received a copy of the "Notice of Privacy Practices" for Hanover Audiology PLLC. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy. This notice is available in our office.

I understand that I may access my medical records at any time and that I may copy and /or inspect my PHI to be used or disclosed in accordance with Hanover Audiology PLLC policy. I understand that Hanover Audiology PLLC may charge me for copies of such records, or completion of medical record forms, however a fee schedule will be provided to me.

I understand that Hanover Audiology PLLC has the right to deny me access to my records in certain circumstances, in accordance with the law; however, in such instance they will provide me with a denial in writing.

AUTHORIZATION FORM FOR USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. It has been explained to the patient that disclosures may be made to family and friends related to the patient's health. It has also been explained that we will only disclose information relevant to current treatment. Our patient has agreed that we will only disclose health care information to (list all that apply):

	In Person	By Phone	Effective
Spouse Name: _____ _____	☐	☐	_/__/__
Parent(s) Name: _____	☐	☐	__/__/__
Sibling(s) Name: _____	☐	☐	__/__/__
Other: _____ (Name) (Relationship)	☐	☐	__/__/__

I, _____, authorize the use or disclosure of my PHI as specified in the Notice of Privacy Practices for Hanover Audiology PLLC. I understand the purpose of the authorized use of disclosure of PHI is for use within Hanover Audiology PLLC or for authorized disclosure from another entity that is subject to the privacy rule to Hanover Audiology PLLC for treatment, payment or health care operation purposes. I also understand

that if the organization authorized to receive my PHI is not a health plan or health care provider, that organization may disclose my PHI. In the event that this happens, I understand that my information may no longer be protected under the federal privacy rule and regulations. I understand that this authorization is voluntary and may be revoked at any time. I understand that I may ask questions of Hanover Audiology PLLC, if I do not understand any information contained in the Notice of Privacy Practices.

_____	_____
(Printed Name of Patient)	(Date)
_____	_____
(Signature of Patient or Patient's Representative)	(Date)
_____	_____
(Printed Name of Patient's Representative)	(Relationship)