ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Please complete all items below

Patient Name: _____ Date of Birth *(mm/dd/yyyy)*: _____

Address: _____ City/State/Zip _____

Phone #: _____

I acknowledge that I received a copy of Marin Hearing Center's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted on the MHC website, that my acknowledgment will be updated at least annually, and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

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

_____
Printed name of patient

_____ _____
Printed name of personal representative (if applicable) Relationship to patient

_____ _____
Signature of patient or personal representative Date

This Notice is effective as of April, 2013; rev 1/1/15; rev 2/13/16, rev 3/21/2019