



# HearAide, Inc.

## HIPAA Privacy Receipt Acknowledgment

HearAide’s Notice of Privacy Practices has been offered to me. I understand I have the right to review the Notice of Privacy Practices prior to signing this document and by signing this document, acknowledge only that I have been offered the Notice of Privacy Practices or have declined the offer.

HearAide reserves the right to change the privacy practices that are described in the Notice of Privacy Practices.

I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Accepted Notice

Declined Notice

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Signature of Personal Representative

\_\_\_\_\_  
Patient’s Date of Birth

\_\_\_\_\_  
Description of Personal Rep’s Authority

\_\_\_\_\_  
Date

I authorize the following person(s) minimal access (does not include copies of medical records) to my protected health information (PHI):

Name	Date of Birth	Home Phone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____

Patient’s Signature: \_\_\_\_\_  
(For authorization to release limited PHI to the above listed individuals)

I further authorize HearAide to communicate with me electronically through e-mail at the following e-mail address: \_\_\_\_\_. I understand that this e-mail communication is not secured by encryption therefore is not considered a secured or private communication. HearAide will not be held responsible for further disclosure of your information sent via unencrypted e-mail.

Patient’s Signature: \_\_\_\_\_  
(Signature for authorization of e-mail communications)