Hear-Again Hearing Center, LLC

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I have received, read and understand the *Notice of Privacy Practices* containing a complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time to obtain a current copy.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that Hear-Again Hearing Center, LLC is not required to agree to my requested restrictions but if they do then they are bound to abide by such restrictions.

AUTHORIZATION TO RELEASE INFORMATION TO FAMILY MEMBERS

Many of our patients allow family members such as their spouses, parents, or children to call and request medical or billing information. Under the requirements of HIPAA, we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical or billing information released to family members, then you must complete and sign this form. Signing this form will give consent to release this information to the friends or family members indicated below. You have the right to revoke this consent in writing at any time.

I authorize/allow Hear-Again Hearing Center, LLC located at 355 Portage Trail, Suite 4 in Cuyahoga Falls, Ohio 44221 to release my medical and/or billing information to the following people:

Name	Relation to Patient
_____	_____
_____	_____
_____	_____

_____

Patient name (please print) Date of Birth

_____

Patient Signature or authorized representative Date