PHC Professional Hearing Care

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

□ By checking this box and signing below, I acknowledge that I was offered a copy of Professional Hearing Care's Notice of Privacy Practices. The Notice provides information about how we may use and disclose the medical information that we maintain about you. We encourage you to read the full Notice. I understand that a copy of the current Notice will be posted in the reception area, the website (if applicable) and that any revised Notice of Privacy Practices will be made available.

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

_____ _____

Printed name of patient or personal representative Date

_____ _____

Signature of patient or personal representative Date