Acknowledgement of Receipt of
Notice of Privacy Practices & HIPAA Authorization

Authorization:

"I have received a copy of this office's Notice of Privacy Practices."

"I hereby authorize the practice to use my name and address and other information about my health to provide communications to me."

Patient Name:_____

Patient's Date of Birth:_____

Signature of Patient or Patient's Personal Representative:

_____ Date:_____

If Personal Representative:

Print Name:_____

Signature:_____

Relationship:_____

HEARING ASSOCIATES

Patient HIPAA Authorization – All Products and Services

To Our Patients:

From time to time, our practice would like to tell patients about products and services that we think may be of interest to them.

When we give patients promotional gifts of nominal value, or recommend products or services in face-to-face communication, we do not require the patient's written authorization. However, we do require a patient's written authorization, under the new HIPAA regulations, before sending other kinds of marketing communications if our practice receives financial remuneration for sending the communications.

I hereby authorize the practice to use my name and address and other information about my health to provide marketing communications to me. I also authorize the practice to disclose such information to a business associate for purposes of sending marketing communications to me.

I understand that the practice may receive financial remuneration for making marketing communications.

I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by HIPAA Privacy regulations.

I understand that I may revoke this authorization at any time, and that my revocation is not effective unless it is in writing and received by the practice's Privacy Official at the following address:

250 South Crescent Drive, Mason City, IA 50401 (Main Office Location)

I understand that if I revoke this authorization, my revocation will not affect any actions taken by the practice before receiving my written revocation.

I understand that I may refuse to sign this authorization, and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan, or eligibility for benefits.

This authorization expires when the following event occurs: **Client provides written notification**

HEARING ASSOCIATES