



Specialty Care Institute

& THE HEARING INSTITUTE

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**Acknowledgment Notice of Privacy Practices (HIPAA)**

I understand under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I have been informed by you and your *Notice of Privacy Practices* containing a more complete description the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. 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 at the address above to obtain a current copy of the *Notice of Privacy Practices*.

**I give permission to be contacted at and leave messages at:**

Home  Cell  Work  E-Mail: \_\_\_\_\_

May we leave a message on your answering machine?  Yes  No

I give permission to be contacted via text messages  Yes  No

Leave message/result with a family member

Please specify family member \_\_\_\_\_

Relationship \_\_\_\_\_

Phone number of family \_\_\_\_\_

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

\_\_\_\_\_  
**Patient Name**

\_\_\_\_\_  
**Relationship to Patient**

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**

Date updated \_\_\_\_\_

\_\_\_\_\_