ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have received a copy of the Notice of Privacy Practices from **Creekside Hearing Aid Service** and have been informed that I can request a copy of the Notice at any time either by hard copy or by e-mail. I have read and understand the Notice and I have had an opportunity to ask questions about the use and disclosure of my health information, and other concerns regarding my health information.

_____ _____

Signature of Patient (or Personal Representative) Date

_____

Printed Name of Patient

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

If you would like to receive information about products and services from our practice, please initial the authorization below:

_____

Initial Here

FOR OFFICE USE ONLY

Notice of privacy practices provided to the individual:

Date: _____

Initials: _____