San Francisco Hearing Center

AUDIOLOGICAL SERVICES OF SAN FRANCISCO

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Please complete all items below

Patient Name: _____ Date of Birth *(mm/dd/yyyy)*: _____

Email:_____ __ Phone #_____

Address: _____ City/State/Zip _____

I acknowledge that I received a copy of SF Hearing Center – Audiological Services of SF's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be available in SF Hearing Center's waiting room, that my acknowledgment may be updated annually, and that a copy of any amended Notice of Privacy Practices is available at each appointment.

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

_____

Printed name of patient

_____ _____

Printed name of personal representative (if applicable) Relationship to patient

_____ _____

Signature of patient or personal representative Date

This Notice is effective as of November, 2019