AHAC
AUDIOLOGY AND
HEARING AID CENTER
A DIVISION OF RISE AUDIOLOGY

Acknowledgement of HIPAA (Health Insurance Portability and Accountability Act

Name: _____

As result of the Health Insurance Portability and Accountability Act (HIPAA), enforced by the U.S. Department of Health and Human Services office of Civil Rights, we are not permitted to release patient information except as stated in the Notice of Privacy Practices, or in accordance with your wishes as stated below.

I received and reviewed AHAC's Notice of Privacy Practices which describes how my medical information may be used and disclosed and explains how I can get access to this information.

I had an opportunity to raise questions regarding this policy and all of my questions have been answered:

_____ yes _____ no

The authorizations made above will remain effective until such time as I notify AHAC's office in writing, of requested changes.

This waiver authorizes Audiology and Hearing Aid Center, LLC (AHAC) to send/give my medical information as noted:

Leave a voicemail recording including my personal health information on the home/cell phone: _____ yes _____ no

Send me an e-mail including my personal health information: _____ yes _____ no

Permit AHAC to share personal health information with other health care providers, family members, and/or school personnel as necessary to carry out my care: _____ yes _____ no

Authorized person(s) to share information with:

_____

_____

Audiology and Hearing Aid Center does not release any health protected information to any outside entity for remuneration for marketing.

Signature of Patient/Legal Guardian:

_____

Date_____