## NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT

I acknowledge that I was provided a copy of Medical Hearing Clinic, Inc., Notice of Privacy Practice Form in accordance with the Federally Mandated H.I.P.A.A Law. I have had time to read and review this Notice, and I have instructions given to me on how to obtain a copy for my personal records, should I desire.

Patient Signature: _____

Date: _____

## MEDICAL AND FINACIAL INFORMATION AUTHORIZATION AND RELEASE

The purpose of this Authorization and Release form is for your protection. The H.I.P.A.A. (Health Insurance Portability Accountability Act) Act of 1996, was created with the sole purpose and goal of protecting patients medical records and financial information. We urge you to complete this form to allow us to better server and protect your private information. Please be specific when designating your choices.

I authorize the staff of Medical Hearing Clinic, Inc. to release and FINANCIAL INFORMATION to the following people:

SPOUSE: _____

PARTNER: _____

PARENT/GUARDIAN: _____

OTHER: _____

I authorize the staff of Medical Hearing Clinic, Inc. to release any MEDICAL INFORMATION to the following people:

SPOUSE: _____

PARTNER: _____

PARENT/GUARDIAN: _____

OTHER: _____

PATIENT SIGNATURE: _____ DATE: _____