Aurora audiology

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Notice of Privacy Practices

PATIENT ACKNOWLEDGEMENT

I acknowledge that Aurora Audiology, LLC has a privacy policy in compliance with HIPAA regulations. The notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information. I am informed that the policy is posted in the public waiting area in two (2) locations for me to read. I understand that a personal copy will be made available to me at my request

I understand that Aurora Audiology, LLC reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information resident at, or controlled by, this practice. If changes to the policy occur, this practice will provide me a revised Notice of Privacy Practices upon request.

Patient's PRINTED Name: _____ DOB: / /

Patient's Signature: _____ Date: / /

❒ Refuse to sign*

*In case of refusal to sign or revoking of the acknowledgement of privacy practices, this organization may refuse to treat you as permitted by Section 164.506 of the Code of Federal Regulations.