Advanced Audiology of Greater Omaha
NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT FORM

By my signature below I acknowledge that I have received the HIPAA Notice of Privacy Practices (the "Notice") from **Advanced Audiology of Greater Omaha** and that I have been provided an opportunity to review it.

I understand that I have certain rights to privacy regarding my protected health information.

I understand that **Advanced Audiology of Greater Omaha** can and will use my health information for purposes of my treatment, payment for treatment and health care operations.

I have read and understand that **Advanced Audiology of Greater Omaha** may use and share my protected health information for other purposes, as described in the Notice.

I understand that I have rights regarding my protected health information as listed in the Notice.

I understand that Advanced Audiology of Greater Omaha has the right to change the Notice from time to time and I can obtain a current copy of the Notice from Advanced Audiology of Greater Omaha at any time.

_____ _____

Patient/Patient's Representative Signature Date

Patient Name (First, MI, Last):_____

Patient Date of Birth
(MM/DD/YY):_____

If you are signing as the Patient's representative:

Print your name (First, MI, Last):_____

Describe your relationship: _____

Internal Use Only:

Good Faith Effort to Obtain Acknowledgement Form

*Patient Name:*_____ *Date:*_____

I attempted to obtain the patient's (or their representative's) signature on this Notice of Privacy Practices Acknowledgement Form, but was unable to do so as documented below:

*Reason:*_____

Name: _____*Signature*:_____