GN Audiology Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name: ___________________________ Date of Birth: ________

Address: ___________________________ City/State/Zip: ______________

Phone Number: ______________________ Email: ____________________

I acknowledge that, in compliance with the Health Insurance Portability Accountability Act (HIPAA), a Notice of Privacy Practices has been presented to me and I understand that a paper copy is available upon request.

I hereby give permission to GN Audiology to send follow-up letters promotional offers, new product information/newsletters to my Email address or physical address.

Please check **Yes** ☐ **or** **No** ☐

____________________________________ ________________

Printed Name of Patient or Personal Representative Date

____________________________________ ________________

Signature of Patient or Personal Representative Date