



HIPAA PRIVACY FORM
NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

This form will be provided to you upon registration. In the case of a medical emergency, this form will be provided to you as soon as reasonably practicable after your emergency treatment is over.

Name of Patient/ Personal Representative:

You are entitled to our **Notice of Privacy Practices** describing how your health information can be used and disclosed by Mid Island Audiology, PLLC and how you can obtain access to and control this information.

Our Notice of Privacy Practices will be provided to you upon registration or admission. It is also posted in our registration areas and is available on our website at www.midislandaudiology.com

We have additional Notices of Privacy Practices for HIV, mental health and alcohol & substance abuse information. You can request a copy of these notices at any time.

Patient/Surrogate Name (Print): _____

Signature: _____

Date: _____

Time: _____

Patient would not acknowledge receipt of Notice of Privacy Practices. Documentation of good faith effort to obtain acknowledgement and reason not obtained:
