



HIPPA ACKNOWLEDGEMENT

I, _____ (Patient/Guardian) acknowledge that I have received a copy of Horizon Audiology, Inc.'s notice regarding Privacy of Personal Health Information.

Patient/Guardian Signature: _____ Date: _____

I agree that the practice may disclose health information to the following:
(Check all that are acceptable to you)

Home Telephone _____

Work Telephone _____

Cell Phone _____

Email _____

Spouse _____ (Name)

Parent _____ (Name)

Leave message with detailed information

OR

Leave message with call back numbers only

The following person(s) are NOT authorized to receive my health information:

Print name(s): _____

AUTHORIZATION AND RELEASE INFORMATION

I hereby authorize Horizon Audiology, Inc. to release any records including information regarding the diagnosis/treatment to my insurance company in order to process my claims, any physicians or any person involved with my health as acknowledged by the HIPAA Notice of Privacy Practices. I authorize payment of the benefits to the physician or supplier for services rendered. I also request the release of payment to be made directly to Horizon Audiology, Inc. This information is on file as a permanent record.

Print Name: _____ Signature: _____

Date: _____