Horizon Audiology, Inc.

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 Address _____

_____ Leave Message with detailed information

OR

_____ Leave message with call back numbers only

_____ Spouse _____ (Name)

_____ Parent _____ (Name)

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 physician 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:____