BURBANK
Audiology Center

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have reviewed the Notice of Privacy Practices. I acknowledge that I may request a copy of the Notice of Privacy Practices for Burbank Audiology Center.

Print Patient Name _____

Signature of Patient _____ Date _____

You may release medical information to:

☐ Parent ☐ Spouse

☐ Child ☐ Other _____

If person signing is not the patient, please print your name and relationship to patient:

Name _____

Relationship _____

I, _____ request a copy of the Notice of Privacy Practices: ☐ Yes ☐ No

For Office Use: Date copy was provided: _____

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