Hearing Advancement Center

NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT

In accordance with Washington state law, we keep a record of the health care services we provide to you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes compels us to do so. Our Notice of Privacy Practices describes in more detail how your medical information may be used or disclosed, and how you can access your information.

With my signature below, I acknowledge receipt of the Notice of Privacy Practices.

Signature: _____ Date: _____

Person(s) allowed information: _____

If the signature is by a personal representative of the patient, please complete the following:

Personal representative's name: _____

Relationship to patient: _____

FOR STAFF USE ONLY

Should patient refuse to sign

Reason for refusal: _____

_____

_____

Staff Signature: _____ Date: _____

☐ Notice was verbally translated Translator's name: _____

Language: _____ Translator's signature: _____

Patient did not receive the Notice due to: ☐ Incapacity ☐ No opportunity

13515 NE 175th St. • Suite D • Woodinville, WA 98072 • phone: (425) 485-8430 • fax: (425) 485-8259 • hearingadvancement.com