

# Acknowledgement of Receipt Form

## Patient HIPAA Authorization — All Products and Services

To Our Patients:

From time to time, our practice would like to tell patients about products/services we think may be of interest.

When we give patients promotional gifts of nominal value, or recommend products or services in face-to-face communication, we do not require the patient's written authorization. However, we do require a patient's written authorization, under the new HIPAA regulations, before sending other kinds of marketing communications if our practice receives financial remuneration for sending the communications. Please acknowledge the below statements:

I hereby authorize the practice to use my name and address and other information about my health to provide marketing communications to me. I also authorize the practice to disclose such information to a business associate for purposes of sending marketing communications to me.

I understand that the practice may receive financial remuneration for making marketing communications.

I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by HIPAA Privacy regulations.

I understand that I may revoke this authorization at any time, and that my revocation is not effective unless it is in writing and received by the practice's Privacy Official at the following address: 250 South Crescent Drive, Mason City, IA 50401 (Main Office Location).

I understand that if I revoke this authorization, my revocation will not affect any actions taken by the practice before receiving my written revocation.

I understand that I may refuse to sign this authorization, and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan, or eligibility for benefits.

This authorization expires when the following event occurs: **Client provides written notification.**

### Authorization

- I have been offered/received a copy of this office's Notice of Privacy Practices.
- I hereby authorize the practice to use my name and address and other information about my health to provide communications to me.

I HAVE READ AND UNDERSTAND ALL OF THE ABOVE INFORMATION.	
<input type="text"/>	<input type="text"/>
Patient Name	Patient's Date of Birth
<input type="text"/>	<input type="text"/>
Patient Signature (A copy of this signature is as valid as the original)	Date
<input type="text"/>	<input type="text"/>
Signature of Personal Representative (If applicable)	Relationship

**Please read carefully and sign below.**

- I give permission to the Practice to release information, verbal and written (contained in my medical record and other related information), to my insurance company, rehab nurse, case manager, attorney, employer, related health care providers, assignees and/or beneficiaries, and all other related persons. Information without patient identifiers may be used for quality purposes.
- I authorize the Practice to contact me for all purposes related to my visit, including marketing-related correspondence, via email, voice mail, and text. I further understand that I can revoke my authorization to receive correspondence via email, voice mail, and text by providing written notification to the Practice.
- I authorize the Practice to use and release my protected health information (i.e., my contact information) for marketing related to hearing care products or services.
- I understand that the practice may receive financial remuneration in exchange for making the marketing communication from or on behalf of the third party whose product or service is being described. I understand that this marketing authorization is in effect until a revocation is received by the Practice.
- I have read all the information on this sheet, completed the answers, and certify this information is true and correct to the best of my knowledge. I hereby give my hearing care provider permission to treat my concerns.
- I consent to the video/audio recording of my appointment, examination, and/or procedure for clinical documentation, treatment planning, quality assurance, training, education, or telehealth purposes as determined by the provider. Participation is voluntary, and I may refuse or withdraw this authorization at any time by providing written notice to the Practice. Any recording will be treated as protected health information, maintained securely in accordance with applicable federal and state privacy laws, and accessed only by authorized personnel with a legitimate need. Recordings will be stored and retained in accordance with applicable legal and record-retention requirements. Revocation will not apply to recordings already created or disclosures already made in reliance on this authorization, and I will not receive compensation for any authorized use.

**I HAVE READ AND UNDERSTAND ALL OF THE ABOVE INFORMATION.**

Patient Signature (A copy of this signature is as valid as the original)

Date

Signature of Parent or Guardian

Date