Notice of Privacy Practices

Our practice is dedicated to maintaining the privacy of your individually indentifiable health information. In conducting our business, we will create records regarding you and the treatment and services we provide you. We are required by law to maintain the confidentiality of health information that identifies you.

We will use and disclose your protected health information with only the physicians you list below. We will also use and disclose your protected health information to obtain payment for the health care services we provide you. We have our office policy regarding all the ways we will keep your information private posted and a copy is available on request.

Receipt of Notice of Privacy Practices – Written Acknowledgement

I, _____ , understand The Hearing Center of Castro Valley is in compliance with the Health Insurance Portability and Accountability Act (HIPAA) and have the ability to request a copy of their HIPPA policy.

X _____ _____

Signature of Patient or Guardian **Date**

If you would like copies of your audiological evaluation sent to or released from your physician(s), please complete the information below. The information must be provided in order for reports to be distributed.

_____

(1) Physician Name Phone/Fax

_____

Address/City/State/Zip

_____

(2) Physician Name Phone/Fax

_____

Address/City/State/Zip

Waiver of Medical Evaluation Requirement

(For use only by those who are 18 years of age or older)

I have been advised by The Hearing Center of Castro Valley that the Food and Drug Administration has determined that my best health interest would be served if I had a medical evaluation by a licensed physician (preferably a physician who specializes in diseases of the ear) before purchasing a hearing aid. I do not wish a medical evaluation before purchasing a hearing aid.

X _____ _____

Signature of Patient or Guardian **Date**