Notice of Privacy Practices

The Strickland Ear Clinic Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. In addition to the copy we have provided you, copies of the current notice are available upon request.

I hereby acknowledge that I have received and read the Strickland Ear Clinic Notice of Privacy Practices, Policies, and Procedures and that I understand my rights and responsibilities as outlined by this document.

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I hereby allow Strickland Ear Clinic to release all medical information to my insurance carrier(s). I understand that I am responsible for my healthcare coverage through my insurance carrier. I agree to accept financial responsibility for all charges which are non-covered and thus not paid to Strickland Ear Clinic by my Insurance carrier(s) for services rendered, this release is valid for life but may be revoked, in writing, at any time. Refusal to sign or revocation of this release will result in me being financially responsible for payment in full at the time of service.

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I hereby authorize Strickland Ear Clinic to use and/or disclose my protected health information as outlined by HIPAA for marketing purposes and/or to contact me, either by mail or e-mail to inform me of advances in hearing healthcare and/or hearing aids. I may revoke this authorization at any time.

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Signature of Patient or Patient's Legal Representative Date

_____ _____

Print Name Relationship to Patient

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Name of Interpreter