

## NOTICE OF PRIVACY PRACTICES

I acknowledge that a copy of the current notice is posted in the reception area and the website and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

**A copy of the Notice of Privacy Practices can also be provided upon request.**

- This Notice informs me how Wisconsin Hearing Aids, Inc. will use my health information for the purpose of my treatment and/or payment for my treatment.
- This Notice will also entail how Wisconsin Hearing Aids, Inc. may use and share my health information for purposes other than treatment, payment and health care operations.
- Wisconsin Hearing Aids, Inc. will also use and share my health information as required/permitted by law.

Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_

Relationships to Patient: \_\_\_\_\_