ACKNOWLEDGMENT REGARDING PROTECTED HEALTH INFORMATION (PHI)

Patient Name	Date of Birth

I have received a copy of the Notice of Privacy Practices provided by Kos/Danchak Audiology. I understand how the clinic will utilize my protected health information (PHI) and my rights regarding my protected health information.

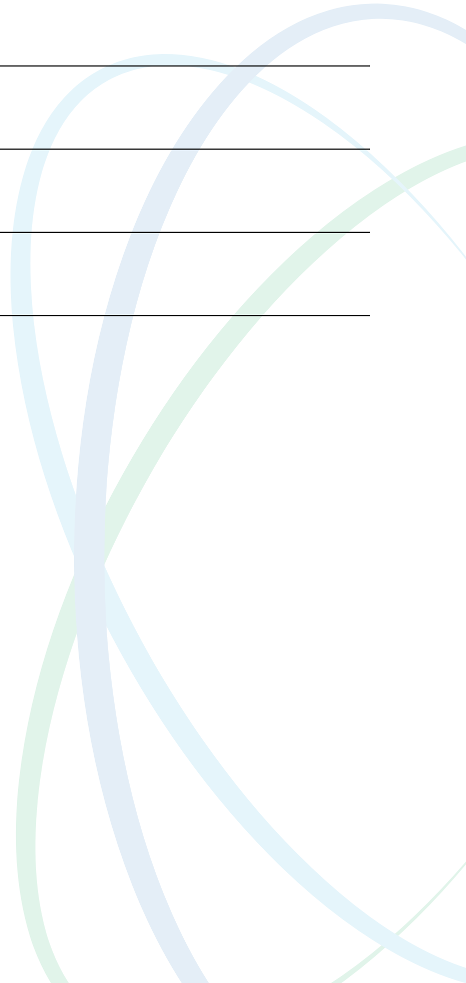
Signature of Patient or Parent/Legal Guardian	Date

****Releasing Information to Me, My Family and Caregivers**

**This is not for physicians or doctors.

I authorize this center to release my PHI (including the evaluation report) to the following people involved in my care (please include yourself, spouse, parents, children, etc., as desired).

Name	Relationship	Phone
	(Myself)	



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