Kos/Danchak
AUDIOLOGY & HEARING AIDS

In general, the HIPAA privacy rule gives individuals the right to request confidential communications or that communications be made by alternative means, such as sending correspondence to the individual's place of business instead of the individual's home.

Patient Name: _____ Date of Birth: _____

Confidential Communications

I wish to be contacted in the following manner (check all that apply):

☐ Home ☐ Work ☐ Cell, which is: _____

OK to leave a message with detailed information: ☐ Yes or ☐ No

Leave a message with your name and a callback # only: ☐ Yes or ☐ No

Written Communication

OK to mail to my home/work/other, which is: _____

_____

Email, which is: _____

_____

RECEIPT of NOTICE of PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT

I, _____, have received a copy of KOS/DANCHAK AUDIOLOGY AND HEARING AIDS NOTICE of PRIVACY PRACTICES.

_____ _____

Signature of Patient or Personal Representative Date

**The Notice of Privacy Practices is available at www.northtxhearing.com as well as in the office upon request.*

Arlington Office - 905 W. Mitchell St., Arlington, TX 76013 - (817) 277-7039
Fort Worth Office - 904 Pennsylvania Ave., Fort Worth, TX 76104 - (817) 332-8817
kdaud.com

Kos/Danchak
AUDIOLOGY & HEARING AIDS

AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR MARKETING PURPOSES

Patient Name: _____ Date of Birth: _____

By signing this form, I am authorizing Kos/Danchak Audiology & Hearing Aids to send me marketing communications for which they may receive financial remuneration from a third party whose products or services are being marketed, such as:

A. Educational and marketing information on products and services offered by Kos/Danchak Audiology & Hearing Aids
B. Communications concerning treatment alternatives or other health-related products or services

**I understand that I have the right to "opt-out" of receiving such communications.*

Other communications for such purposes that do not involve financial remuneration are adequately captured in this practice's Notice of Privacy Practices (NPP).

Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice to the contact office listed below. I understand that revocation of this authorization will not affect any action the above-named entity took in reliance on this authorization before the above-named entity received my written notice of revocation.

Contact Office: Kos/Danchak Audiology & Hearing Aids **Phone:** (817) 277-7039 **Fax:** (817) 801-3231
Email: info@kdaud.com **Address:** 905 W Mitchell St., Arlington, TX 76013

I understand that this authorization is voluntary and that Kos/Danchak Audiology & Hearing Aids cannot condition my treatment, services, etc., on the signing of this authorization. I understand that if I am signing on behalf of a minor child, this authorization will expire upon the child reaching the age of 18 unless there is proof of legal guardianship.

Patient or Personal Representative Signature: _____ Date: _____

Employee Who Reviewed Intake of Form: _____ Date: _____

_____ _____
Signature of Patient or Legal Guardian Date