Kos/Danchak
AUDIOLOGY & HEARING AIDS

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)	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____