HIPAA Notice of Privacy Practice

Contra Costa Hearing Aid Center, Inc
1196 Boulevard Way Ste 1
Walnut Creek, CA 94595
Rachelle: CFO 925-658-1290 Privacy Officer

Our practice is dedicated to maintaining the privacy of your individually identifiable health information, including audiograms. In conducting our business, we will create records regarding you and the treatment and services we provide you. We are required by law to maintain the confidentiality of health information that identifies you.

My Protected Health Information (PHI) means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical health or mental health condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I consent to Provider's use or disclose of my PHI for purposes of delivering relevant product and/or technology marketing communication to me. I acknowledge that Provider may receive financial remuneration from the manufacturer in connection with such communications.

We will use and disclose your protected health information with only the physicians that you list on your intake. We will also use and disclose your protected health information to obtain payment for health care services that we provide you. We have our office policy regarding all the ways that we will keep your information private posted and a copy is in the waiting room.

I _____ hereby acknowledge that Contra Costa Hearing Aid Center is in compliance with The Health Insurance Portability and Accountability Act (HIPAA). I further acknowledge that a copy of the current notice has been posted in the reception area, and that a copy of any amended Notice of Privacy Practices will be available at each appointment.

I would like to receive a copy of any amended Notice of Privacy Practices by e-mail at:

_____.

Signed: _____ Date: _____

Print Name: _____ Telephone: _____

If not signed by the patient, please indicate relationship:

_____ Parent or Guardian of minor patient

_____ Guardian or Conservator of an incompetent patient

Name and Address of Patient:

IF Patient refuses to sign the Acknowledgement:

Efforts to Obtain:

Reason for Refusal:
