

# *Parker & Castle Rock Centers for* **AUDIOLOGY**

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

This Form is to acknowledge I have been informed of Privacy Practices for Parker / Castle Rock Center for Audiology. In accordance with the requirements of the federal regulation "HIPPA Privacy Rule", we are requesting your signature on this form as verification that you have had the opportunity to read and/or receive a copy of our privacy practices.

The Privacy Rule portion of the HIPPA regulations requires our practice to submit a copy of the Notice of Privacy Practices to each patient, both existing and new. Due to the length of document, each patient is offered the opportunity to read a laminated copy of the Notice, which is available at the front desk, or given a copy upon request. You may also request to speak to our Privacy Officer if you have any questions or concerns. If the patient refuses to sign this acknowledgement of receipt, this practice is not obligated to treat said patient.

I have been provided the opportunity to read and/or receive a copy of the Notice of Privacy Practices from:  
Parker / Castle Rock Center for Audiology.

\_\_\_\_\_  
Print Name of Patient and any Authorized Party

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

**Date:** \_\_\_\_\_