# AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

We provide you with important diagnostic information about your hearing. We feel it is important for your physician to have this information for your medical records. **I give my permission for Great Day Hearing to obtain and release my medical records so that they can better understand my condition and help me.** This release will be in effect until we receive a written notice from you requesting we may no longer forward this information.

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**PATIENT/GUARDIAN'S SIGNATURE** **DATE**

# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (HIPAA)

I acknowledge that **I may request a copy** of Great Day Hearing's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area and the website.

- This Notice informs me how Great Day Hearing will use my health information for the purposes of my treatment and/or payment for my treatment.
- This Notice explains in more detail how Great Day Hearing may use and share my health information for other than treatment, payment, and health care operations.
- Great Day Hearing will also use and share my health information as required/permitted by law.

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**PRINT NAME of patient or guardian**

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**SIGNATURE of patient or guardian**

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**DATE**

530 Greenville Blvd. SE Suite A
Phone (252) 479-6757
Fax (252) 298-5056