PRIVACY POLICY FORM

FOR OFFICE USE ONLY	
Sycle ID: _____	Date: _____/_____/_____

Our office is fully committed to compliance with HIPAA guidelines by:

1. Providing appropriate security for our patient records.
2. Protecting the privacy of our patient's medical information.
3. Providing our patients with proper access to their medical records, once a signed release is obtained.
4. Appropriately maintaining our patient information and billing process in compliance with national HIPAA standards.
5. Not providing patient data to marketers or pharmaceutical companies for purpose of research.

I acknowledge that I have read and understand the privacy policy of My Hearing Centers. I understand that a copy of these policies will be presented to me upon request.

Signature: _____ Date: _____/_____/_____

Patient Name: _____