UNIVERSITY OF THE
PACIFIC

HEARING & BALANCE CENTER

Notice of Privacy Practices Patient Acknowledgment

Effective May 14, 2014

University of the Pacific
Department of Audiology
155 Fifth Street
San Francisco, CA 94103

Patient Name: _____ Date of Birth: _____

By signing this form, you acknowledge receipt of the Notice of Privacy Practices from University of the Pacific. The Notice of Privacy Practices provides information about how we may use and disclose your protected health information. We encourage you to review it carefully. The Notice of Privacy Practices is subject to change. If the Notice is changed, you may obtain a revised copy by visiting our website at www.upacifichearing.com or on request from our staff.

I acknowledge receipt of the Notice of Privacy Practices from University of the Pacific.

Signature: _____

Relationship to Patient: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature of this Notice of Privacy Practices Form, but was unable to do so.

Date: _____ Name: _____

Reason: _____

_____