ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

□ By checking this box and signing below, I acknowledge that I received a copy of Gaston Hearing Center's Notice of Privacy Practices. I understand that a copy of the current Notice will be posted in the reception area, the website (if applicable) and that any revised Notice of Privacy Practices will be made available.

- This Notice informs me how Gaston Hearing Center will use my health information for the purposes of my treatment and/or payment for my treatment.

- This Notice explains in more detail how Gaston Hearing Center may use and share my health information for other than treatment, payment and healthcare operations.

- Gaston Hearing Center will also use and share my health information as required/permitted by law.

_____ _____

Printed name of patient or personal representative Date

_____ _____

Signature of patient or personal representative Date