

ACKNOWLEDGMENT OF RECEIPT OF NOTICE

**Professional Speech & Hearing Specialists
40 SW 12th Street, Suite B 202 & C 201
Ocala, Florida 34474**

I hereby acknowledge that I am aware of the HIPPA Privacy Act and that a copy of said Act is available to me for the asking.

Signed: _____ **Date:** _____

Print Name: _____ **Telephone:** _____

If not signed by the patient, please indicate relationship:

- Parent or guardian of minor patient**
- Guardian or conservator of an incompetent patient**
- Beneficiary or personal representative of deceased patient**

Name of Patient: _____

For office use only:

Signed form received by: _____

Acknowledgment refused:

Efforts to obtain: _____

Reason for refusal: _____