**MOSA Audiology**

**Acknowledgment of Receipt of Notice of Privacy Practices**

***Authorization to discuss my medical record with other people:***

In order for MOSA Audiology to be authorized to discuss any treatment and business (billing) issues in person and /or over the phone on my behalf, that person MUST be listed below:

NAME OF PERSON: _____

Relationship to Patient: _____

NAME OF PERSON: _____

Relationship to Patient: _____

NAME OF PERSON: _____

Relationship to Patient: _____

Health information that is NOT to be released or discussed with ANYONE should be described here:

_____

_____

_____

This form should be updated (initial and re-dated) every year to remain valid, unless revoked in writing by the above patient or responsible parent or legal guardian.

I acknowledge that I received a copy of the MOSA Audiology Notice of Privacy Practices and Financial Policy.

Print patient name: _____

Patient Signature: _____

Parent or Legal Guardian of a Minor child/patient: _____

Date: _____

MOSA Representative/Witness: _____