ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Your health information is important to you and also important to this office.

Your health information is recorded in many ways. All of this information is subject to protection by certain state and federal laws from inappropriate release to others.

The privacy practices that we follow to protect your health information are contained in our "Notice of Privacy Practices."

The "Notice of Privacy Practices" explains in detail how medical information about you may be used and disclosed and how you can get access to this information. It also explains your health information rights and the responsibilities of this office when it comes to your health information.

We are required to provide to you a copy of our "Notice of Privacy Practices" and that we obtain your signature that you received a copy of the "Notice of Privacy Practices."

By signing below I acknowledge that I was made aware of and received a copy of the "Notice of Privacy Practices" from the Tallgrass Balance, Hearing & Physical Therapy, LLC.

_____

Patient's Name- PRINTED

X _____ X _____

Patient's SIGNATURE Date signed

_____

Patient's Personal Representative's Name- PRINTED (if applicable)

_____

Patient's Personal Representative's Name- SIGNATURE

_____

Personal Representative's Address and Telephone Number

_____

Personal Representative's Capacity /Authority to act for Patient

The Balance Center at Tallgrass
601 SW Corporate View, Suite 220
Topeka, KS 66615
785-228-6100