ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have received a copy of Integrity Hearing Aid Solutions, Inc. Notice of Privacy Practices. I have read and understand the Notice and I have had an opportunity to ask questions about the use and disclosure of my health information, and other concerns regarding my health information.

I authorize Integrity Hearing Aid Solutions, Inc. to make me aware, by telephone, mail, or email of products or services that may be of interest to me in better hearing.

_____ _____

Signature of Patient (or Personal Representative) Date

_____

Printed Name of Patient (or Representative if applicable)

I authorize _____ to be present for my hearing evaluation, demonstration, and audiogram hearing records.