YUCHA HEARING AIDS
435 West Cedarville Road
Pottstown, PA 19465
610 326-6114

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have received a copy of Yucha Hearing Aids 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 Yucha Hearing Aids 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 Personal Representative)

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