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Acknowledgement of Privacy Practices

* Summary: Hearing Associates of Las Vegas, LLC, and all of its employees, will not share your health information with anyone without your permission.

By signing below, I acknowledge that I have reviewed Hearing Associates of Las Vegas, LLC's Notice of Privacy Practices. I have read and understand the Notice and have had an opportunity to ask questions about the use and disclosure of my health information, and other concerns regarding my health information.

______________________________________ ____/____/______
Signature of Patient (or Personal Representative) Date

____
Printed Name of Patient

____
Printed Name of Personal Representative