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Erica L. F. Regan, AuD, Nancy K. Charest, AuD, Racheal Rush, AuD

Patient Name: _____ Date of Birth: _____
Home Phone: _____

Privacy Act Acknowledgment

I have been provided the opportunity to review the Notice of Privacy Practice of Professional Audiology. (A copy is posted in the office)

(Signature of patient or Guardian)

(Relationship)

Patient Record of Disclosure

It is ok to contact me in the following manner (check all that apply)

☐ O.K. to send mail to my home address ☐ O.K. to Text ☐ O.K. to Email

☐ Home Telephone ☐ Cellular Phone ☐ Work Telephone

☐ OK to leave message with detailed information on answering machine

☐ OK to leave message with spouse or other (Name and Relationship): _____

☐ Leave message with call back number only

The audiologists/office staff of Professional Audiology may discuss my medical condition and/or history with: Please check all boxes that apply

☐ Husband/Wife _____ ☐ Daughter/Son _____

☐ Sister/Brother _____ ☐ Mother/Father _____

☐ Friend _____ ☐ Other _____

Signature

Date