hear for you
HEARING AID CENTER

Enjoy the sounds of life!

CONSENT TO COMPLY WITH FEDERAL HIPAA ACT

Patient Consent for Use and Disclosure of Protected Health Information

With my consent and signature, Hear for You Hearing Aid Center, LLC. may use and disclose protected health information about me or my child to:

1. Carry out treatment, payment, and healthcare operations (services)
2. Call my home or other designated locations and leave a message on voicemail in reference to any items (i.e. appointment reminders, insurance items, references to clinical care or test results, etc.) that will assist in the practice of medical care for me or my child.
3. Mail to my home or other designated address any item (i.e. appointment reminder cards, patient financial statements, etc.) that will assist in practice of medical care for me or my child. Such correspondence is to be marked personal and confidential.
4. Send or transmit email to any location provided by me for all above similar items and purposes.
5. To use and/or disclose protected health information about me or my child to/with third parties involved in mine or my child's care. Such parties may include, but are not limited to, insurance companies, hospitals, and specialty physicians. I may specifically describe the type of information (i.e. dates of services, level of detail, origin of information, etc.) subject to disclosure and may revoke this permission at a time and date chosen by me. By providing a written statement to Hear for You Hearing Aid Center, I may revoke this permission; however Hear for You Hearing Aid Center may decline to provide further treatment to me or my child. Hear for You may also decline further treatment to me or my child should my restrictions on the type of their party information, in the opinion of Hear for You, impede medical care of me or my child.

I have the right to review the Notice of Privacy Practice Manual of Hear for You Hearing Aid Center. Hear for You may revise its manual and procedures at any time deemed necessary, and I may request from time to time, in writing, a copy of such changes, should these changes directly relate to mine or my child's care.

I have the right to request that Hear for You Hearing Aid Center restrict how it uses or discloses mine or my child's health information. However, as stated previously, Hear for You is not required to agree to my restrictions. If Hear for You accepts my restrictions, they are bound by the restriction in the agreement, setting forth the restricted information until providing me, in writing, a cessation of such agreement.

I may revoke this entire consent, in writing, at any time. If I do not sign this consent, or revoke this consent, Hear for You Hearing Aid Center, in their sole discretion, may decline further treatment for me or my child.

The Federal HIPAA (Privacy Act) of 2001 was created to protect mine or my child's health information. I understand that this must be accomplished within the provisions and rules set up by Hear for You Hearing Aid Center to fulfill federal law. I may request to review the manual which spells out these provisions. Hear for You Hearing Aid Center will strive to provide information so that I may make an informed decision concerning the privacy or mine or my child's medical information.

_____ _____

Patient's Signature (or Parent/Legal Guardian of Minor Child) Date of Signature

_____ _____

Patient Name Patient Date of Birth

_____ _____

Printed Name of Signature Above Initials of Witness