



HIPPA Policy

Name _____ Date of Birth _____

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have review our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPPA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to revoke consent in writing at anytime and all full disclosure will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

PLEASE ANSWER THE FOLLOWING QUESTIONS

May we phone, email, or send a text to confirm appointments?	Yes	No
May we leave a message on your answering machine at your home or cell phone?	Yes	No
May we discuss hearing care options, pricing, outcomes with family or personal associates?	Yes	No

Signature _____ Date _____