

Patient Name: _____ **Date of Birth:** _____

Patient Address: _____

Email Address: _____

By signing below, I hereby authorize the use/or disclosure of individually identifiable health information and/or medical, audiological or hearing aid records relating to me, which are called “protected health information” or “PHI” under the Health Insurance Portability and Accountability Act of 1996 or “HIPAA”, as described below:

Per the Omnibus Rule effective September 23, 2013, it is required by law that our organization will notify you of any accidental breaches that may occur.

1. I consent to receive audiological services from Uthe Hearing Aid and Audiology Services, LLC. This consent encompasses:
 - (a). Audiological procedures including but not limited to: diagnostic testing, rehabilitative treatment, ear wax removal, and taking of ear mold impressions.
2. I understand that this consent form will be valid and remain in effect as long as I receive audiological care from Uthe Hearing Aid and Audiology Services, LLC.
3. I hereby authorize the release of any medical or other information necessary to process my insurance claim. I further authorize payment of medical benefits to Uthe Hearing Aid and Audiology Services, LLC for the services described on the insurance form. This authorization is to apply to all occasions of service until it is revoked in writing.
4. I understand that if the person or entity that received this information is not a health care provider or health plan covered by HIPAA, the released information may be re-disclosed by the recipient and may no longer be protected by federal or state law.
5. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY, HEALTH PROVIDER, HEARING AID MANUFACTURER OR INDIVIDUAL SPECIFIED BELOW** (*this does not include Uthe Hearing Aid and Audiology Services, LLC and their employees*):
6. I authorize Uthe Hearing Aid and Audiology Services, LLC to leave a message on my answering machine/voice mail box or messenger via cell phone, or email to remind me of an appointment.

(Check yes or no) Yes No

7. I authorize Uthe Hearing Aid and Audiology Services, LLC to send out correspondence or appointment reminders in the mail.

(Check yes or no) Yes No

8. **(a). Specific information to be released: (Check box)**
 - Audiological Records All dates past and present**
 - OR from (insert date) ___/___/___ to (insert date) ___/___/___

Records to include:

 - Audiogram, tympanogram, and speech results**
 - Audiological history**
 - Otoscopy**
 - Hearing aid information**
 - Check here for all of the above**

Authorization to discuss health information

- (b). By initialing here _____ I authorize Uthe Hearing Aid and Audiology Services, LLC to discuss my health information with whom I’ve listed here:

Initials

Medical Physician: _____
(Name) (Location)

Individual(s): _____
(Names/s)

Other (Please specify): _____

9. If not patient, name of person signing the form: _____

10. Relationship to the patient. Documentation of POA required: _____

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form if I requested.

Signature of patient or representative authorized by law

Date