HIPAA

(Health Insurance Portability and Accountability Act)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I understand that as part of my health care, The Hearing Doctor originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment.

I understand that this information serves as:

°A basis for planning my care and treatment,
°A means of communication among the many health professionals who contribute to my care,
°A source of information for applying my diagnosis to my bill,
°A means by which a third party payer can verify that services billed were actually provided, and
°A tool for routine health care operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand that and have been provided with a NOTICE OF PRIVACY PRACTICES that provides a more complete description of information uses and disclosures.

I understand that I have the following rights and privileges:

°The right to review the notice prior to signing this consent,
°The right to object to the use of my health information for directory purposes, and
°The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

I understand that The Hearing Doctor is not required to agree to the restrictions request.

I understand that I may revoke this consent in writing, except to the extent the organization has already taken action in reliance on theron.

I also understand that by refusing to sign this consent or revoking the consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that The Hearing Doctor reserves the right to change its notice and practices and, prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations, should The Hearing Doctor change its notice, it will send a copy of any revised notice to the address I've provided (whether it is by U.S. Mail or, if I agree, email.

I wish to have the following restrictions to use or disclose my health information:

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I understand that as part of this organization's treatment, payment, or health operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept the terms of this consent with my signature.

_______________________________ _______________________________
Printed Name **Date**

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Signature

For Office Use Only:
( ) Consent received by: ______________________________ on: ______________________________
( ) Consent refused by patient, and treatment refused as permitted.
( ) Consent added to the patient's medical record on ______________________________.

5607 114th Street, Ste. 100
Lubbock, Texas 79424
info@myhearingdoc.com myhearingdoc.com
P: 806-798-3600 F:806-798-3601