Hearing Healthcare Center

3101 N. Green River Rd., Ste. 510, Evansville, IN 47715 * (812) 303-4300 * www.HearBetterEvansville.com

HIPAA

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand the information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain reimbursement for you from third party payers.
- Conduct normal healthcare operations such as quality assessments and staff certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to read and review your Notice of Privacy Practices prior to signing this consent. I understand this organization has the right to change its Notice of Privacy Practices from time to time and I may contact the organization's office to obtain a current copy of the Notice of Privacy Practices.

I understand I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand you are required to agree to my requested restrictions and, if agreed, you are bound to abide by such restrictions.

I understand I may revoke this consent in writing at any time, except to the extent you have taken action relying on this consent.

Client Name (printed): _____

Signature: _____ Date: _____

Relationship to client (if a minor): _____

PERSONAL HEALTH REPRESENTATIVES AND CONTACT INFORMATION

May we leave a message concerning test results?

On your answering machine or voice-mail? ✔ Yes or No ✔

With another person? ✔ Yes or No ✔

May we leave a detailed message regarding appointments or billing information?

On your answering machine or voice-mail? ✔ Yes or No ✔

With another person? ✔ Yes or No ✔

Please list the person(s) with whom we can discuss your protected health information:

_____

_____

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