# Patient Consent Form

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 (PHI). I understand that this information can and will be used as outlined in Freedom Hearing Center's **Notice of Privacy Practices**. Specifically, I understand that my PHI will be used to:

- ✓ Conduct, plan and direct my treatment and follow-up among multiple Healthcare providers who may be involved in that treatment directly and indirectly.
- ✓ Obtain payment from third-party payers (i.e. my insurance company).
- ✓ Conduct normal healthcare operations such as quality assessments and physician certifications.
- ✓ Provide appointment reminders, warranty expiration reminders, information about treatment alternatives, other related health information, or products/services that may be of interest to me.

I have been informed of your **Notice of Privacy Practices** policy containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such **Notice of Privacy Practices** prior to signing this consent. I understand that this organization has the right to change its **Notice of Privacy Practices** from time to time, and that I may contact this organization at any time by telephone or at the address below to obtain a correct copy of the **Notice of Privacy Practices**. I may also find the most recent **Notice of Privacy Practices** online at www.freedomhearing.com.

I understand that I may request verbally or in writing that you restrict how my private information is used and disclosed to carry out treatment, payment, or healthcare operations, but you are not required to agree to these requested restrictions. However, if you do agree, then you are bound to comply with this restriction.

I understand that I may revoke this consent in writing at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Other than yourself, with whom else may we share/discuss results? ______________________________________________

Patient Name: ______________________________________________ Date: ____________________________________

Signature: ___________________________________________________ Relationship to patient: ___________________

*If you have questions, and would like additional information, you may contact Freedom Hearing Center and ask to speak with our HIPAA Privacy Officer, Pamela McIntyre at 443-295-7100.


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