FREEDOM
Hearing Center LLC

Patient Consent Form

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and 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.
- ✓ Conduct normal healthcare operation such as quality assessments and physician 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 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 at the address below to obtain a correct copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used to disclose to carry out treatment, payment, or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Signature: _____

Relationship to patient: _____

Date: _____

Main Contact Information for all Offices:
(p) 443-295-7100
(f) 443-295-7555

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Leonardtown, MD 20650

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7247 Hanover Parkway
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