Family Hearing Services

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Patient Authorization of Disclosure

In general, the HIPAA Privacy Rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). My "protected health information" (“PHI”) means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I consent to Provider’s use or disclosure of my PHI for purposes of delivering relevant product and/or technology marketing communication to me. I acknowledge that Provider may receive financial remuneration from the manufacturer in connection with such communications.

The individual is also provided the right to request confidential communications of PHI be made by alternative means, such as sending correspondence to the individual’s office instead of the individual’s home. The patient may revoke or change this authorization at any time with a written request.

I wish to be contacted in the following manner (Circle all that apply):

Home Phone: ☐ *Yes* ☐ *No* **Cell Phone:** ☐ *Yes* ☐ *No* **Work Phone:** ☐ *Yes* ☐ *No*
O.K. to leave message with detailed information: ☐ *Yes* ☐ *No*

Written Communication
O.K. to mail or market to my home address: ☐ *Yes* ☐ *No*

In a further effort to protect your health information and the confidentiality of your healthcare, we ask that you designate below to whom the staff at Family Hearing Services may discuss your healthcare and scheduling needs as well as billing issues that may arise.

Name_____ Relationship_____ Phone_____

Name_____ Relationship_____ Phone_____

Other (i.e. Physician, Employer, etc.)_____

Patient/Guardian Signature:_____ **Date:** _____