Audio Professional Hearing Centers Today's Date:______/______/_______

NOTICE OF PRIVACY PRACTICES AND POLICIES CONSENT FORM

I give permission to Audio Professional Hearing Centers to release my protected health information (PHI), verbal and written, contained in my medical record to my health insurance company, related healthcare providers, Audio Professional Hearing Centers' business associates when required to complete my care, and to the individuals listed below:

_______________________________________ ___________________________________
Name of Individual Relationship to Patient

_______________________________________ ___________________________________
Name of Individual Relationship to Patient

_______________________________________ ___________________________________
Name of Individual Relationship to Patient

All other requests for information must be submitted in writing to Audio Professional Hearing Centers, by the patient or assignees.

In order for Audio Professional Hearing Centers to mail me their newsletter, I authorize Audio Professional Hearing Centers to disclose my name and address to our marketing partners, for the sole purpose of mailing. I understand that Audio Professional Hearing Centers or it's marketing partner may receive financial remuneration in exchange for making the marketing communication from or on behalf of the third party whose product or service is being described. **All protected health information, i.e.; name and address, will never be sold.**

I have been informed of and have available to me, Audio Professional Hearing Centers' complete Notice of Privacy Policy pursuant to HIPAA. The Notice provides information about how we may use and disclose the medical information that we maintain about you, and we encourage you to read the full Notice. I understand that a copy of the current Notice will be posted in the reception area, the website and that any revised Notice of Privacy Practices will be made available. I understand that I am entitled to receive a copy of the Notice of Privacy Practices at any time.

I acknowledge and agree that regardless of my health insurance status, I am ultimately responsible for the balance of my account for professional services rendered and/or purchases made.

CONSENT FOR TREATMENT

I consent to receive audiological services from Audio Professional Hearing Centers. This consent encompasses audiological procedures including, but not limited to, diagnostic testing, rehabilitative treatment, ear wax removal, and taking of earmold impressions. I understand that this consent form will be valid and remain in effect as long as I receive audiological care from Audio Professional Hearing Centers.

I have read all the information on this sheet and have completed the above answers, certify this information is true and correct to the best of my knowledge and hereby give Audio Professional Hearing Centers permission to treat my concerns.

____Date: ______/______ /________
Patient Signature or Parent/Guardian if Patient is a Minor

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Print Name