Professional Hearing Solutions

Permission for Exchange of Information

(Health Information Portability and Accountability Act)

I request and authorize PROFESSIONAL HEARING SOLUTIONS to disclose my protected health information as described below. I understand that if the person/organization authorized to receive and use the information is not a health plan or health care provider, the disclosed information may no longer be protected by federal privacy regulations.

☐ I consent to PROFESSIONAL HEARING SOLUTIONS releasing protected health information to the following professionals or persons:

_____ _____

_____ _____

----------OR----------

☐ I **PROHIBIT** the release of my protected health information by Professional Hearing Solutions to any person or entity other than what is required by law

.

Things I understand:

*I have the right to request a restriction as to how my protected health information may be used or disclosed by PHS.
*This authorization is in effect until PHS receives written notification of revocation.
*Not signing this form prohibits the release of protected health information except where required by law.

Acknowledgement of Availability of the Notice of Privacy Practices

☐ By checking this box and signing below, I acknowledge that I have had access to PHS's Notice of Privacy Practices.

The notice provides information about how PHS may use and disclose the protected health information that we maintain. We encourage you to rad the full notice. A copy of the current notice is available in the reception area and on the website. Any revisions of the Notice of Privacy Practices will be made available upon request.

Payments from Insurance Companies and/or Medicare

I request that payment of authorized Medicare and/or private insurance benefits be made either to me or on my behalf to **PROFESSIONAL HEARING SOLUTIONS, INC.** for any services furnished to me by PHS. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

_____ _____

PATIENT SIGNAURE **DATE**

☐ I allow PHS to send me material in the mail. I understand that the material may have information regarding a specific manufacturer or product and it may be sponsored by a specific product.

☐ I give PHS permission to contact me through email, telephone, and/or the postal service for the purpose of medical care only.

----------OR----------

☐ I **DO NOT** give permission to PHS to contact me.