HEARING PROFESSIONALS
DOCTORS OF AUDIOLOGY
PERSONALIZED HEARING CARE & BALANCE CENTER

Patient Consent Form

I understand that under the Health Insurance Portability & Accountability Act of 1996 (**HIPAA**), 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 Practice**.

I understand that I may request in writing that you restrict how my private information is used or disclosed 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.

I understand that you may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: _____

Signature: _____

Relationship to Patient: _____

Date: _____

Laurel
14201 Laurel Park Drive, 109
Laurel, MD 20707
301-604-3177

Bowie
4000 Mitchellville Road, B124
Bowie, MD 20716
301-464-2036

Waldorf
3460 Old Washington Rd, 203
Waldorf, MD 20602
301-932-4237

California
23077 Three Notch Road, 101
California, MD 20619
301-737-4040