BOUNTIFUL HEARING CENTER • PLLC

Patient Consent Form

Our notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Bountiful Hearing Center provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- Bountiful Hearing Center has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- Bountiful Hearing Center reserves the right to change the Notice of Privacy Practices.
- The patient has the right to restrict the uses of their information but the Bountiful Hearing Center does not have to agree to those restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- Bountiful Hearing Center may condition receipt of treatment upon the execution of this Consent.

Receipt of Notice of Privacy Practices

I, _____, hereby acknowledge receipt of the audiologist's Notice of Privacy Practices. The Notice of Privacy Practice provides detailed information about how the practice may use and disclose my confidential information.

- I understand that the audiologist has reserved a right to change his or her privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided to me or made available.

_____ _____ ____/____/_____

Printed Name – Patient or Representative | Signature | Date

_____

Relationship to Patient (if other than patient)

_____ _____ ____/____/_____

Printed Name – WITNESS TO PATIENT SIGNATURE | Signature | Date

The following individuals may have access to my information:

_____

Name | Phone # | Relationship to patient | Date

_____

Name | Phone # | Relationship to patient | Date