

La Cañada Hearing Aids & Audiology

Patient Consent for Use and Disclosure Of Protected Health Information

I hereby give my consent for **La Cañada Hearing Aids & Audiology** to use and disclose protected health information (*PHI*) about me to carry out **treatment, payment** and **health care operations (TPO)**.

I have the right to review the Notice of Privacy Practice prior to signing this consent.

- **La Cañada Hearing Aids & Audiology** reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to **La Cañada Hearing Aids & Audiology**.
- With this consent, **La Cañada Hearing Aids & Audiology** may call my home or other alternative location and leave a message on voicemail or in person with reference to any items that assist the practice in carrying out *TPO*, such as appointment reminders, insurance items, and any calls pertaining to my clinical care, including test results, among others.
- With this consent, **La Cañada Hearing Aids & Audiology** may mail to my home or other alternative location any items that assist the practice in carrying out *TPO*, such as appointment reminder cards and patient statements.
- With this consent, **La Cañada Hearing Aids & Audiology** may e-mail to my home or other alternative location any items that assist the practice in carrying out *TPO*, such as appointment reminder cards and patient statements
- I have the right to request that **La Cañada Hearing Aids & Audiology** restrict how it uses or disclose my *PHI* to carry out *TPO*. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement
- By signing this form I am consenting to allow **La Cañada Hearing Aids & Audiology** to use and disclose my *PHI* to carry out *TPO*.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke, **La Cañada Hearing Aids & Audiology** may decline to provide treatment to me.

Signature of Patient or Legal Guardian

Print Patient's Name

Date

Print Name of Parent or Legal Guardian (if applicable)