ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name:_____ Date of Birth:_____

Address: _____ City/State/Zip_____

Social Security #:_____ Phone #:_____

I acknowledge that I received a copy of Audiology Associates Inc.'s Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, the website (if applicable) and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

- This Notice informs me how Audiology Associates Inc. will use my health information for the purposes of my treatment and/or payment for my treatment.

- This Notice explains in more detail how Audiology Associates Inc. may use and share my health information for other than treatment, payment, and health care operations.

- Audiology Associates Inc. will also use and share my health information as required/permitted by law.

_____ _____

Printed name of patient or personal representative Date

_____ _____

Signature of patient or personal representative Date

Authorization and Release for the Use and/or Disclosure of Protected Health Information for Marketing

Patient Name: _____ Date of Birth: _____

Address: _____ City/State/Zip _____

Social Security #: _____ Phone #: _____

I authorize Audiology Associates Inc. to use/disclose my protected health information for marketing related to audiological/health-related products or services. I understand that Audiology Associates Inc. or its business associates 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.

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 Authorize Audiology Associates Inc. to use and disclose medical information for any and all marketing purposes and understand that Audiology Associates Inc. or its business associate may receive financial remuneration in exchange for making the marketing communication for on behalf of the third party whose product or service is being described. A list of anticipated and potential persons/class of persons/organizations to whom information may be disclosed is included below.

□ I request an Authorization form for each instance Audiology Associates Inc. intends to use and disclose medical information for any marketing purposes and understand that Audiology Associates Inc. or its business associate may receive financial remuneration in exchange for making the marketing communication or on behalf of the third party whose product or service is being described.

□ I prohibit Audiology Associates Inc. from using and disclosing medical information for any marketing purposes.

A list of anticipated and/or potential persons/class of persons/organizations to whom information may be disclosed:

_____

_____

_____

_____

_____

If you need assistance in completing the authorization form, please contact Melissa Segev, at (410) 266-6444 or msegev@aaiaudiology.com.

I understand that I have the right to request restrictions as to how my protected health information may be used or disclosed by Audiology Associates Inc.

I understand that this authorization is in effect for the term set forth below or until the revocation section of this form is signed and received. I may revoke this authorization at any time by signing the revocation section of my copy of this form and returning it to **Audiology Associates Inc.**

I authorize Audiology Associates Inc.'s use and disclosure of my protected health information as set forth above. I understand that this authorization is voluntary and that Audiology Associates Inc. cannot condition my treatment, services, etc… on the signing of this authorization. I understand that if I am signing on behalf of a minor child, this authorization will expire upon the child reaching the age of 18, unless there is proof of legal guardianship.

_____ _____

Printed name of patient or personal representative Date

_____ _____

Signature of patient or personal representative Date

EXPIRATION/REVOCATION SECTION

Expiration: This authorization will expire on (must choose one):

☐ One year from the date it is signed
☐ Other (insert date or event):_____

Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice to the address listed at the bottom of this form. I understand that revocation of this authorization will not affect any action the above named entity took in reliance on this authorization before the above named entity received my written notice of revocation.

I hereby revoke this authorization.

_____ _____

Printed name of patient or personal representative Date

_____ _____

Signature of patient or personal representative Date

Authorization to Use and Disclosure of Health Information

Patient Name:_____ Date of Birth:_____

I request and authorize Audiology Associates Inc. 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 Audiology Associates Inc. releasing protected health as detailed below.

_ I prohibit Audiology Associates Inc. from using and disclosing medical information to any person or entity other than required by HIPAA regulations.

My protected health information may be used or disclosed to the following:

_____

For the Purpose of:

_____

If you need assistance in completing the authorization form, please contact Melissa Segev, at (410) 266-6444 or msegev@aaiaudiology.com. I understand that I have the right to request restrictions as to how my protected health information may be used or disclosed by Audiology Associates Inc. I understand that this authorization is in effect until the revocation section of this form is signed or until written notice of revocation is received. I may revoke this authorization at any time by signing the revocation section of my copy of this form and returning it to Audiology Associates Inc. I authorize Audiology Associates Inc.'s use and disclosure of my protected health information as set forth above. I understand that this authorization is voluntary and that Audiology Associates Inc. cannot condition my treatment, services, etc... on the signing of this authorization. I understand that if I am signing on behalf of a minor child, this authorization will expire upon the child reaching the age of 18, unless there is proof of legal guardianship.

_____ _____

Printed name of patient or personal representative Date

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Signature of patient or personal representative Date

EXPIRATION/REVOCATION SECTION

Expiration: This authorization will expire on (must choose one):

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I hereby revoke this authorization.

_____ _____

Printed name of patient or personal representative Date

_____ _____

Signature of patient or personal representative Date

Audiology Associates Inc.

9613-I Harford Road, Baltimore MD, 21234