1303-B River Valley Blvd. Lancaster, Ohio 43130

NOTICE OF PRIVACY PRACTICES AND MARKETING CONSENT

Patient Name: _____

D.O.B: _____

Date: _____

PATIENT PRIVACY POLICY: I acknowledge that I have been offered a copy of Audiology Associates of Lancaster's Notice of Privacy Practices, if I so desire, for my personal use and retention.

Signature_____

AUTHORIZATION FOR HEALTH CARE MARKETING COMMUNICATIONS:

I authorize Audiology Associates of Lancaster to use or disclose my name, address, or email address for the purpose of sending me materials and coupons/discount offers that market or promote hearing aids. This information will never be sold to a third party.

Signature_____

THIS CONSENT CAN BE REVOKED BY THE PATIENT AT ANY TIME IN WRITING TO THE ADDRESS ABOVE

1303-B River Valley Blvd. Lancaster, Ohio 43130

HIPAA RELEASE OF INFORMATION AUTHORIZATION FORM

Patient Name: _____

D.O.B: _____

Date: _____

AUTHORIZATION FOR RELEASE OF INFORMATION: I authorize use or disclosure of protected health information about me as described below:

The following person/class of person/facility is authorized to receive/disclose information about me:

Audiology Associates of Lancaster

The following person (or class of persons) may receive/disclose protected health information about me:

_____

_____

_____

_____

_____

Specific information that should be disclosed/received is: audiologic/medical information for continuity of care.

I understand that the information used/disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and then would no longer be protected by federal privacy regulations.

I may revoke this authorization by notifying Audiology Associates of Lancaster in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

Signature_____