

**CENTRAL ILLINOIS HEARING, LTD.
PATIENT CONSENT FORM**

Rev: 2/29/16

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 the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers (insurance carriers, discount plans, etc.)
- Conduct normal healthcare operations such as quality assessment and physician certifications.
- For marketing related to hearing care products or services.

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. (One is posted in the waiting room or you may ask the secretary for a copy if you want one for your records.) 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 current copy of the *Notice of Privacy Practices*.

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

List the persons you allow to have access to your records/information:

| | | |
|------------|--------------------|--------------|
| Name _____ | Relationship _____ | Phone: _____ |
| Name _____ | Relationship _____ | Phone: _____ |

Patient Name: _____

Signature: _____

Relationship to Patient: (self, spouse, daughter, etc.) _____

Date: _____