Erie Audiology, INC.

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CONSENT FOR USE AND/OR DISCLOSURE OF HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

Client Name:

_____

(Last) **(First)** **(Middle Initial)**

Date of Birth:_____

I understand that any of my personal health information may be used and/or released by **Erie Audiology, Inc.** for purposes of carrying out treatment, receiving payment, and carrying out other health care operations of the corporation. I have been given the opportunity to review **Erie Audiology, Inc.'s** Notice of Privacy Practices, which I understand provides a more complete description of how my health information may be used or released. I understand that it is my right to review the Notice of Privacy Practices before I sign this consent. I also understand that the terms of the Notice of Privacy Practices may change. I understand that I may obtain a copy of the Notice of Privacy Practices at any time from **Erie Audiology, Inc.**

I understand that I have a right to request that **Erie Audiology, Inc.** limit how my health information is used or released to carry out treatment, payment or other health care operations. I also understand that **Erie Audiology, Inc.** is not required to agree to any such request. I understand that if **Erie Audiology, Inc.** agrees to my request, the limitations will be followed by **Erie Audiology, Inc.**

I understand that I have a right to revoke or cancel this consent by filling out and signing a written revocation form which is available from **Erie Audiology, Inc.** I also understand that, if I choose to revoke or cancel my consent, it can only be revoked or cancelled to the extent that **Erie Audiology, Inc.** has not already released the information.

By signing below, I hereby voluntarily and knowingly consent to allow **Erie Audiology, Inc.** and any of its staff, employees and/or agents, to use and/or release my health information as deemed appropriate to carry out treatment, payment and/or other health care operations of the organization.

X _____ _____

Signature of client or legal representative **Date**

If you are the legal representative of the client, please check off the basis for your authority:

☐ Power of Attorney (attach copy) ☐ Parent of Minor

☐Guardianship Order (attach copy) ☐ Other _____

_____ _____

Reviewing Erie Audiology, Inc. Staff Member Date