Erie Audiology

Allison F. Keenan, Au.D., F.A.A.A.
Doctor of Audiology

2550 West 8th Street, Erie PA 16505
814/833-9533 • Fax 814/833-1621

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

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Name _____ Claim # _____

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Erie Audiology for any services furnished to me by that provider of service and (or) supplier. I authorize any holder of medical information about me to release to the Centers for Medicare Services and its agents any information needed to determine these benefits or the benefits payable for related service.

Signature _____ Date _____

Name _____ ID # _____

I request that payment of my authorized insurance benefits (ex: Highmark, AARP, United Health, etc.)be made either to me or on my behalf to Erie Audiology for any services furnished to me by that provider of service and (or) supplier. I authorize any holder of this insurance information about me to release to _____ any information needed to determine these benefits or the benefits payable for related service.

Signature _____ Date _____