HIPPA Privacy Authorization

85 E Street
South Portland, ME 04106
207-808-9097

Are there people you want to be able to:

- Make/ Cancel appointments on your behalf?
- Discuss your healthcare with your physician?
- Pick up Supplies?
- Discuss your financial statement or insurance concerns?

Name:_____ Relationship: _____ Phone: _____

Name:_____ Relationship: _____ Phone: _____

Name:_____ Relationship: _____ Phone: _____

I give permission to Tailored Hearing. to release my protected health information (PHI), verbal and written, contained in my medical record to my health insurance company in order to submit claims, related healthcare providers, and Tailored Hearing business associates when required to complete my care. All other requests for information must be submitted in writing to Tailored Hering, Inc., by the patient or assignees.

I authorize Tailored Hearing, Inc. to release my personal health information (e.g. contact information) for third party marketing related to hearing care products or services. I understand that Tailored Hearing, Inc. or its marketing partners 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.

[ ] CHECK HERE if you **do NOT** want to receive third party marketing regarding hearing care, products or services, including our newsletter.

I have been informed of and have available to me, Tailored Hearing Inc.'s complete Notice of Privacy Policy pursuant to HIPAA. The Notice provides information about how we may use and disclose the medical information that we maintain about you, and we encourage you to read the full Notice. I understand that a copy of the current Notice will be posted in the reception area, the website and that any revised Notice of Privacy Practices will be made available. I understand that I am entitled to receive a copy of the Notice of Privacy Practices at any time.

Request to receive confidential communication by:

Home Phone Number:_____ Written Communication:_____

___ok to leave message with detailed information ___ok to mail to address listed above

___leave message with call back number only ___email me at: _____

Work Phone Number:_____ Cell Phone Number: _____

___ok to leave message with detailed information ___ok to leave message with detailed information

___leave message with call back number only ___leave message with call back number only

I acknowledge and agree that regardless of my health insurance status, I am ultimately responsible for the balance of my account for professional services rendered and/or purchases made. I also acknowledge and agree that if any balance on my account remains unpaid after attempts have been made to collect, my account may be sent to a collection agency and incur additional fees.

I have read all the information on this sheet and have completed the above answers, certify this information is true and correct to the best of my knowledge and hereby give Fagan Center for Audiology, Inc. permission to treat my concerns. This agreement will expire one year from the date of signature below, unless previously revoked or otherwise indicated here: _____

_____ _____

Print Patient Name: D.O.B.

_____ _____/_____/_____

Patient Signature or Parent/Guardian Date

Must be signed by the patient or legal guardian. If you have legal paperwork that designates you as the Durable Power of Attorney, please provide copies of the paperwork to the Fagan Center for Audiology. **NOTE: As a designated advocate for the patient, this does not allow any designee to request records on the Patient. Such action will require a signed from the patient or DPOA.**