SHA
Sumter Hearing Associates
Quality. Education. Commitment.

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www.sumterhearing.com
1116 F Alice Drive - Sumter, SC 29150
23 South Mill St. – Manning, SC 29102

HIPAA Disclosure/Authorization Release/Receipt Form

Name: _____ Date of Birth: _____

A. My signature below indicates that I consent to the disclosure/use by Sumter Hearing Associates (SHA) of complete audiological evaluations with applicable history, testing, results, hearing aid information and recommendations for treatment, payment and healthcare operations as described in our privacy policy.

***Signature*: _____ Date: _____**

B. I authorize SHA to exchange PHI [Private Health Information] with: Initials Date

Primary Care Physician:_____ _____ _____

ENT Physician: _____ _____ _____

Agency&County: _____ _____ _____

Attention: _____

Family member: _____ _____ _____

Other: _____ _____ _____

Attention: _____

This authorization may be revoked by a request in writing. I understand the recipient may re-disclose this information.
I understand charges for duplication of my records may be incurred.

C. I DO ____, DO NOT ___, give permission for SHA to contact me with postcard reminders and/or promotional information.

D. I hereby acknowledge that I have read and/or received a copy of this practice's Notice of Privacy Policies.

***Signature*: _____Date: _____**

If not signed by the patient, please indicate relationship: _____

For those with Medicare: I understand that Medicare does not pay for a diagnostic hearing evaluation without a physician referral, or for any hearing aid related services. 1 understand that as the patient I will be responsible for those charges.

***Signature.*_____ _____ Date: _____**

REVOCATION SECTION I hereby revoke this authorization.

***Signature:* _____ Date: _____**

For office use only: Received by: _____ Refused to sign Reasons:_____ updated 9/2018