

HIPAA - Authorization for the Use or Disclosure of Protected Health Information

I consent to the use or disclosure of my protected health information (including audiograms) by Marietta Hearing Center (“provider”) for the purpose of diagnosing or providing hearing care and treatment to me. I understand that diagnosis or treatment of me by Provider may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out hearing care and treatment. Provider is not required to agree to the restrictions that I may request. However, if Provider agrees to a restriction that I request, the restriction is binding on Provider. I have the right to revoke this consent, in writing, at any time, except to the extent that Provider has taken action in reliance on this consent.

My “protected health information “ (PHI) means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I consent to Provider’s use or disclosure of my PHI for purposes delivering relevant product and/or technology marketing communication to me. I acknowledge that Provider may receive financial remuneration from the manufacturer in connection with such communications.

My protected health information may be used or disclosed to the following person(s):

Name	Relation to patient
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Name	Relation to patient
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Signature of Patient or Personal Representative

Printed Name of Patient or Personal Representative

Date	Relation to Patient	
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