# KRICKET AUDIOLOGY, LLC
# HIPAA

**In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their Protected Health Information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI will be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.**

**I wish to be contacted in the following manner for appointments**

***Check all that apply***

□Home/ cell telephone Home/Cell number_____
Leave message with appointment date and time
Leave message with call back number only
Do not leave message

□Work Telephone Work Number_____
Leave message with appointment date and time
Leave message with call back number only
Do not leave message

□Written Communication
Mail to my home address _____
Mail to my work address _____

□Electronic Communication email address_____

**Patient/Parent Signature_____Date_____**
**Print Name_____Patient date of birth_____**

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use of disclosure of, and the requests for PHI to the minimum necessary to accomplish the intended prupose. These provisions do not apply to uses or disclosures made pursuant to an authorization request by the individual.

Healthcare entities mus keep records of PHI disclosures. Information provided below, if completed properly, will constitute an adequate record.

**NOTE: Uses and disclosures for reasons other than treatment, payment or operations may be permitted without prior consent in an emergency.**

**The following names listed are those that I give Kricket Audiology, LLC the authorization to give health information regarding appointments, test results and hearing aids to:**
_____Relationship_____
_____Relationship_____
_____Relationship_____
_____Relationship_____

**___DO NOT PROVIDE health information regading appointments, test results and hearing aids to anyone but me.**
My signature below acknowledges that I have been proved with a copy of the Notice of Privacy Practices (Version Effective 11/01/2014).

**Signature of Patient/Legal Guardian _____Date_____**
(To be completed if patient refuses to sign acknowledgement)
Date _____Name of person providing notice_____