Colorado Tinnitus and Hearing Center, Inc.

3601 South Clarkson Street, Suite 220
Englewood, Colorado 80113
Phone 303-534-0163 Fax 303-534-0179

www.helpforringing.com

Connecting People with the Sounds of Life

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION, PLEASE REVIEW IT CAREFULLY.

Colorado Tinnitus and Hearing Center, Inc. is required by law to maintain the privacy of health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. You have a right to a complete paper copy of our **Notice of Privacy Practices**. If you have any questions about any part of this notice or if you would like to have a more detailed explanation of these rights, please contact:

Colorado Tinnitus and Hearing Center, Inc. at 3601 South Clarkson Street, Suite 220, Englewood, CO 80113, 303-534-0163.

Colorado Tinnitus and Hearing Center, Inc. collects health information from you and stores it in a chart and on a computer. This is your medical record. The medical record is the property of **Colorado Tinnitus and Hearing Center, Inc.,** but the information in the medical record belongs to you.

Your information is used and protected with the strictest confidence. Your information will only be transmitted to other parties; example, insurance companies, lawyers or other medical providers with your written consent. With regards to treatment, if another treatment provider is treating you, we may discuss your case in order to coordinate care between us. The kinds of health care information we may disclose about you in such circumstances could include your diagnosis, hearing test results, etc. We also may use your information to process your insurance claim. If someone, other than you or your insurance company should require copies of your files, we will need a written authorization from you for the release of this information to that person.

We may also contact you by phone, mail or email, to provide appointment reminders or to give you information about other treatments or health related benefits and services that may be of interest to you.

I have been informed of the policies by which my information is used and transmitted. I hereby authorize the release of any medical or other information necessary to process this claim. I also authorize payment of medical benefits to **Colorado Tinnitus and Hearing Center, Inc (CTHC)** for services rendered.

Signature___________________________________
Date____