Jacobs Audiology

Patient Consent for Use and Disclosure of Protected Health and Financial Information

I hereby give consent for Jacobs Audiology, LLC to use and disclose protected health information (PHI) about me, to carry out treatment, payment and healthcare operations (TPO). I also hereby give my consent to Jacobs Audiology, LLC to use the disclosed financial information to help obtain financial aid for hearing aids from Jacobs Audiology, LLC. I realize this information may be released to different charity groups for review and decisions regarding possible financing.

With this consent Jacobs Audiology, LLC may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist this clinic to carry out TPO, such appointment reminder cards and patient statements and other notices.

With this consent Jacobs Audiology, LLC may email to my home or other alternative location any items that assist this clinic in carrying out TPO, such as appointment reminder cards and patient notifications and/or patient notification and/or statements.

- In addition I authorize use of this form on ALL my insurance submissions.
- I authorize release of information to all my Insurance Companie(s).
- I understand that I am responsible for my bill.
- I authorize Jacobs Audiology, LLC to act as my agent in helping me obtain payment from my Insurance Companie(s).
- I authorize payment direct to Jacobs Audiology, LLC.
- I permit a copy of this authorization to be used in place of the original.

Patient Name: _____

Patient Signature:_____**Date:** _____