HIPPA Notice of Privacy Practices

Patient Name: _____or

Patient Representative: _____Relationship to Patient_____

In providing service to you we create and store health information that identifies you. We understand that this information about you and your health is personal, and we are committed to protecting the privacy of this information. We must obtain your written consent before we treat you, obtain payment and provide services. *Please read carefully the information below before signing this form.*

I give this practice my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for health care operations like quality review.

I have been informed that I may review the practices Notice of Privacy Practices (for a more complete description of uses and disclosures) before signing this consent.

I understand that this practice has the right to change their privacy practices and that I may obtain any revised notices at the practice.

I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that the practice is not required to agree to the request. If the practice agrees to my requested restriction, they must follow the restrictions (s).

I also understand that I may revoke this consent at any time, by making a request in writing, except for the information already used or disclosed.

I have read this consent and understand it. I consent to the use and disclosure of my health information for the purposes of treatment, payment, and health care operations.

May we contact you via email: ____YES ____NO
Do we have permission to leave a voice mail for appointment reminder? ____YES ____NO

I _____, hereby authorize State Hearing and Audiology, P.C.to release protected health information (diagnosis, reports, testing and treatment) for myself or_____ to the following people:

_____	_____
Name	Relationship to Patient/Telephone Number
_____	_____
Name	Relationship to Patient/Telephone Number
_____	_____
Name	Relationship to Patient/Telephone Number

I understand that I may revoke this authorization at any time by notifying State Hearing and Audiology, P.C. in writing at the address noted below. I further understand that this authorization will expire by law 180 days from the date of this authorization unless I otherwise specify.

_____ _____
Signature of Patient or Personal Representative Date

State Hearing and Audiology, P.C., 6609 State Route 56, Suite 11, Potsdam, NY 13676

Phone: 315-508-4327, Fax: 315-262-0300, email: statehearing@yahoo.com