Patient Name: _____ Date of Birth: _____

HIPAA Acknowledgement

I understand that a copy of the Privacy Policy for this office is available to me upon request. The Notice provides information about how we may use and disclose the medical information that we maintain about you. You will have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the contact person listed below. Please understand that revocation of this consent will not affect any action we take in reliance on this consent before we received your revocation. An electronic format of this Privacy Practice is available upon request by contacting the person below. Pinnacle Hearing Aid Center, LLC will NEVER sell your information for any purpose. By signing below, I authorize Pinnacle Hearing Aid Center, LLC to send me educational and/or marketing information on the products and services offered by Pinnacle Hearing Aid Center, LLC. No remuneration is involved in this communication. I understand that I may revoke this authorization, in writing, at any time.

Consent of Release for Protected Health Information (PHI)

I give permission to Pinnacle Hearing Aid Center, LLC to release information, verbal and written (contained in my medical record and other related information), to myself (parent/guardian), insurance company, related healthcare providers, case manager, rehab nurse, my attorney, employer, assignees and/or beneficiaries, and all other related persons.

Please read and answer the following statements:

Messages may be left on my answering machine or voicemail	Yes____ No_____
Messages may be left with others if they answer the phone	Yes____ No_____
I may be called at work if the number has been provided	Yes____ No_____
Correspondence may be mailed to my home	Yes____ No_____
Correspondence may be sent by text	Yes____ No_____
Correspondence may be sent by email	Yes____ No_____

I hereby give the following people permission to receive information from this office on my behalf:

(This is usually a spouse, partner, family member, close friend, guardian, etc.)

Name of Person: _____Relationship to me: _____ Phone: _____

Name of Person: _____Relationship to me: _____Phone: _____

I understand that I have the right to request restrictions as to how my protected health information may be used or disclosed by Worth Hearing Center and that this authorization is in effect until written notice of a revocation is received. This consent will expire 10 years from the date below, unless I provide a request with a different date.

Signature: _____ Date: _____

You may obtain a copy of our Notice of Privacy Practices, including any revisions of that Notice, at any time by contacting: Pamela Kreps Address: 759 Horizon Dr., Ste E, Grand Junction, CO 81506 Phone: 970-628-4927 Email: info@pinnaclehearingaidcenter.com