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

I hereby give my consent for **Modern Otoacoustics LLC d/b/a The Hearing Aid Shop** to use and disclose Protected Health Information (PHI) about me to carry out treatment, payment, and healthcare operations. (The Notice of Privacy Practices provided by **The Hearing Aid Shop** describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent agreement. The Hearing Aid Shop reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to **The Hearing Aid Shop, PO Box 1175, Wolfeboro, NH 03894**.

With this consent, **The Hearing Aid Shop** 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 the practice in carrying out treatment protocols such as: Appointment reminders, insurance items, and any calls pertaining to my clinical care, including labratory test results, among others.

With this consent, **The Hearing Aid Shop** may call my home or other alternative location and leave a message on voicemail or in-person in reference to any items that assist the practice in carrying out treatment, payment, and operations such as: Appointment reminder cards and patient statements and invoices.

With this consent, **The Hearing Aid Shop** may email my home or other alternative location any items that assist the practice in carrying out treatment, payments, and operations such as appointment reminders, patient statements, and invoices.

I have the right to request that **The Hearing Aid Shop** restrict how it uses or discloses my PHI to carry out typical pratice operations. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this agreement, I am consenting to allow **The Hearing Aid Shop** to request the release of my medical records, including patient history, office notes, test results, health, audiograms, and verify health insurance coverage and eligibility for continuity of care.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this agreement, or later revoke it, **The Hearing Aid Shop** may decline to provide treatment to me.

By signing this agreement, I agree that The Hearing Aid Shop has provided me with the Notice of Privacy Practices and that I understand and accept its contents.

Date: MM/DD/YY

Print Patient Name and Date of Birth