Health Information Consent

I understand that Shoals Hearing Clinic, P.C. uses and discloses patient information to provide treatment, to obtain payment, and for health care operations, including administrative purposes. By signing below, I consent to such use and disclosure of the patient's information. I also consent to the use and disclosure of the patient's health information from which all identifying information has been removed.

I understand that before signing this consent, I have the right to review Shoals Hearing Clinic, P.C.'s Notice of Information Practices for more information about how my protected health information may be used and disclosed. I understand that Shoals Hearing Clinic, P.C. may change its information practices, but before doing so, a new Notice will be posted in the waiting area and in each examination room. I may also request a copy of this notice.

I understand that I have the right to request restrictions on certain uses and disclosures of my health information. Shoals Hearing Clinic, P.C. does agree, it must abide by those restrictions. I understand I have the right to revoke this consent, in writing, except where Shoals Hearing Clinic, P.C. has already made disclosures in reliance of my prior consent.

Name of Patient _____(Please Print)

Signature of Patient or Legal Representative

If signed by someone other than patient, print name:

_____Relation _____