Audiology Associates of East Texas
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Tyler, TX 75703
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CONSENT TO USE AND DISCLOSE PRIVATE HEALTH INFORMATION

Your protected health information will be used by Audiology Associates of East Texas and/or David L. Twomey, Audiologist, or disclosed to others for the purpose of treatment, obtaining payment (insurance carriers) and the day-to-day health care operations of this practice. Your protected health information may be disclosed to your primary care physician and referring physician. In the case of the purchase of a hearing aid, your hearing test results will be furnished to the manufacturer. ***Additionally, your protected health information may also be disclosed to family members who you list below:***

______________________________ ______________________________
Name Relationship

______________________________ ______________________________
Name Relationship

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your protected health information may be used or disclosed. You may review the notice prior to signing this consent.

Requesting a Restriction on the Use or Disclosure of Your Protected Health Information

You may request a restriction on the use or disclosure of your protected health information. Audiology Associates of East Texas may or may not agree to restrict the use or disclosure of your protected health information. If Audiology Associates of East Texas agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected health information in violation of an agreed upon restriction will be a violation of federal privacy standards.

Audiology Associates of East Texas reserves the right to modify the privacy practices outlined in this notice.

Revocation of Consent

You may revoke this Consent to Use and Disclose Private Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

I have reviewed this consent form and give my permission to Audiology Associates of East Texas to use and disclose my health information in accordance with it.

____ ____/____/____
Signature of patient, parent, or guardian Date

____
Printed name of patient, parent, or guardian