Amplisound Statement of Privacy

As part of Amplisound's business and/or hearing care operations, it may become necessary to disclose your protected health information to another entity.

The **Patient Information Act** (enforced by the office of Inspector General) allows Amplisound to contact the patient (you), your primary care physician, hearing aid manufacturers, and other specific individuals chosen or approved by you as the patient, and to disclose your protected health information, including but not limited to: hearing test data and observations resulting from physical examination of the ear.

I have been afforded the opportunity to review a **Notice of Privacy Practices**, which provides a more detailed descriptions of information uses and disclosures.

I understand I have the following rights and privileges:

- The right to review the Notice of Privacy Practices prior to signing this consent.
- The right to object to the use of my health information for directory purposes.
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

I wish to have the following restrictions to the use or disclosure of my health information.

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I consent to such disclosure for permitted uses and authorize Amplisound to send, fax, or otherwise distribute information pertaining to my hearing, hearing aid(s), and/or appointments in the following situations or circumstances:

☐ Medical doctor or doctor specializing in diseases of the ear.
☐ An entity for payment or hearing care operations.
☐ A hearing aid manufacturer or ear mold lab.
☐ Mail information to my home.
☐ Confirm appointments by calling my home, leaving a message with household members, or leaving a voice recording on my home answering machine.
☐ Discuss details of my case with family members or other individuals.

Names:_____

Signature _____ Date _____