Appalachian Hearing and Speech Center

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HIPAA Consent Authorization

HIPAA Notice of Privacy Practices Acknowlegement

I have had access to or received, read, understand your Notice of Privacy Practices. I understand that this information will be used to carry out treatment, payment, and normal healthcare operations of the Practice. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Authorization to Obtain and Release Medical Records

I hereby authorize all physicians, health care entities, and pharmacies participating in my health care to obtain, release, use, and disclose my entire medical record by mail, phone, fax, and electronic transmission in order to carry out my treatment, payment and healthcare operations.
Lifetime Signature on File (Applies to Medicare patients)
I request that payment of authorized Medicare benefits be made on my behalf directly to Appalachian Hearing and Speech Center for any services furnished to me by the practice. I authorize the release of any and all medical or other information necessary for processing claims to the Center for Medicare and Medicaid Services (CMS).

Authorization for Assignment of Insurance Benefits, Information Release and Financial Responsibility

I authorize the payment of medical benefits be made on my behalf directly to the Practice for any services furnished to me by the physician or practice. I understand that I am financially responsible for any amount not covered by my insurance. I authorize the release to my insurance co. any and all information concerning health care, advice, or treatment provided to me necessary for processing insurance claims. I understand if my insurance requires a prior authorization for office visits, procedures, inpatient or outpatient surgery, tests or services, it is my responsibility to make sure the authorization is obtained prior to the visit, procedure, test, or service being performed. I understand that if I am seen without an authorzation I will be considered a self-pay patient and will be required to pay in full for all services performed. I agree to pay any and all charges that are not covered or are not paid by my insurance plan. I agree that if my account should be turned over for collection, I agree to pay any and all collection agency fees, attorney fees, legal fees and court costs.

Health Care Operations

I understand that the practice may use or release PHI for health care operations. Examples of these are:
Contacting providers and clients with information about other forms of treatment, Case management and coordination of health care, Activities to analyze trends relating to improving health or reducing health care costs, Quality assurance activities (including audits by third parties), Utilization review, including review by independent organizations not connected with Appalachian Hearing and Speech Center, when the reviewis requested by the Client and/or provider. We may use or release your PHI for these or other activities that fall under this definition: for example, in order to make certain that you are receiving the appropriate care, to evaluate our performance in caring for you and the services we provide, or to contact you and to remind you about an appointment. Occasionally, we will use you demographic information for the mailing of newsletters or to contact you concerning hearing aid promotions we may be having. If you wish that your information not be used for our mailings, please contact the Privacy Officer in writing.

If you would like anyone other than yourself (friend/family member) to have access to your information, please complete the section below. I understand that authorization for release of information can only be revoked upon written notice.

Name	**Relationship**	**Phone #**	**HIPAA Billing HIPAA Medical**
Name	**Relationship**	**Phone #**	**HIPAA Billing HIPAA Medical**

By signing below, I acknowledge that all sections of this form have been read in full and explained as necessary.

Legal Name of Patient or Responsible Party _____

Signature Required: _____ **Date:** _____