SHA
Sumter Hearing Associates *Sumter Hearing Associates*
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HIPAA Disclosure/Authorization Release/Receipt Form

Name: _____ **DOB:** _____

My signature below indicates that I **consent to the disclosure/use** by Sumter Hearing Associates (SHA) of complete audiological evaluations with applicable history, testing, results, hearing aid information and recommendations for **treatment, payment and healthcare operations** as described in our privacy policy. I DO____, DO NOT____ give permission for SHA to be contact me with postcard reminders and/or promotional information.

* *Signature*: _____ Date: _____

A. I authorize SHA to exchange PHI with the following: **Signature** **Date**

Primary Care Physician:_____ _____ _____

ENT Physician:_____ _____ _____

Agency & County:_____ _____ _____
Attention:_____

Family member:_____ _____ _____

Other: _____ _____ _____
Attention:_____

Other:_____ _____ _____
Attention:_____

Each authorization expires one year from the date of the signature. This authorization may be revoked by a request in writing. I understand the recipient may redisclose this information. I understand charges for duplication my records may be incurred.

B. I hereby acknowledge that I have read this practice's Notice of Privacy Policies.

* *Signature*: _____ Date: _____

If not signed by the patient, please indicate relationship: _____

For those with Medicare I understand that Medicare does not pay for a diagnostic hearing evaluation without a physician referral, or for any hearing aid related services. I understand that as the patient I will be responsible for those charges.

Signature: _____ Date: _____

REVOCATION SECTION I hereby revoke this authorization.

Signature: _____ Date: _____

For office use only: Received by:_____ Refused to sign ___ Reasons:_____

_____