CONSENTS AND RELEASE OF PROTECTED HEALTH INFORMATION

Permission to Release Records

We provide you with important diagnostic information about your hearing. We feel it is important for your physician to have this information for your medical records. It is sometimes necessary to release diagnostic information in order to process insurance claims and insurance applications. By signing this form you are giving us permission to send a copy to your physician and release diagnostic information to your insurance company. This release will be in effect until we receive a written notice from you requesting we may no longer forward this information. You also authorize payment of hearing benefits to Advanced Audiology, Inc.

____ ____________________
Signature of patient or adult responsible party Date

Permission to Receive Records

In order to provide you with the best service possible, we may be required to contact your previous Audiologist, Hearing Instrument Specialist, Ear-Nose and Throat Physician and/or Hearing Aid Manufacturer for information regarding your hearing health and hearing instrument information. This release will be in effect until we receive a written notice from you requesting we no longer receive this information.

____ ____________________
Signature of patient or adult responsible party Date

Permission to Send Mail

I consent to Advanced Audiology's use or disclosure of my protect health information for purposes of delivering relevant product and/or technology marketing communication to me. I acknowledge that Advanced Audiology may receive financial remuneration for the manufacturer in connection with such communications. By signing this request you are giving us permission to for the above. This will be in effect until we receive a written notice from you requesting we may no longer call you.

____ ____________________
Signature of patient or adult responsible party Date

Do we have your permission to do the following:

Leave a message that we called on your answering machine at home?	☐ Yes	☐ No
Leave a message that we called at your place of employment?	☐ Yes	☐ No
Discuss your medical information with any member of your household?	☐ Yes	☐ No

____ ____________________
Signature of patient or adult responsible party Date

MEDICARE PATIENTS ONLY:

I authorize any holder of medical or other information about me to be releases to the social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

____ ____________________
Signature of patient or adult responsible party Date

If you have a supplemental policy and it is a **MEDIGAP** policy to which your Medicare Carrier automatically "crosses over", Advanced Audiology is required to keep a separate signature on file:

I request authorized MEDIGAP benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the above MEDIGAP carrier any information needed to determine these benefits payable for the related services.

____ ____________________
Signature of patient or adult responsible party Date