HEALTH INFORMATION PRIVACY PROTECTION ACT (HIPPA)

Patient/Customer's Name: _____ Date of Birth: _____

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I. Consent for Release of Information

1. Release of Information. I authorize Grand Hearing Center to disclose and furnish copies of any information relating to my care at Grand Hearing Center (including any information related to substance abuse, mental health, HIV/AIDS, or other sensitive issues), to:

   - any person or health care provider Grand Hearing Center believes to be involved in my care;
   - any third party payor or other party that may provide health-related benefits to me or may be financially responsible for the services I receive;
   - any other person or organization I may specify in writing; and
   - as allowed by applicable state and federal law, any other persons or organizations as necessary for my treatment, payment or Grand Hearing Center's health care operations.

   In certain cases, such as when I request to have my records sent to another provider, I understand that Grand Hearing Center may charge me, and I agree to pay, a copying fee for Grand Hearing Center's costs in photocopying or otherwise reproducing the records.

2. Effective Date/Revocation. I understand that I may revoke this consent at any time by giving written notification to Grand Hearing Center. This consent expires on the earlier of: (i) the date Grand Hearing Center receives a written notice of revocation; or (ii) the date that the consent expires in accordance with governing law. I understand that my revocation will be ineffective to the extent Grand Hearing Center has relied upon the permission granted in this consent.

3. Additional Rights. I understand that a more detailed description of my rights regarding my records can be found in Grand Hearing Center's Notice of Privacy Practices.

II. Payment Authorization

1. Payment Responsibility. I agree that I am responsible to pay Grand Hearing Center for all services furnished to me at Grand Hearing Center, including any and all amounts which are not paid for by my insurance.

III. Acknowledgement of Receipt of Notice

1. Acknowledgement. By signing below, you are acknowledging that you have received a copy of our Notice of Privacy Practices.

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_____ _____

Signature of patient/customer (or patient/customer's representative): Date

Print Name of Patient/Customer _____

**If you are signing as the patient's/customer's representative:**

Print your name: _____

Describe your authority: _____

7/12/2011