Audiology Concepts Edina
6444 Xerxes Ave South
Edina, MN 55423
Phone: 952.831.4222
Fax: 952.831.4942
www.audiologyconcepts.com

HIPAA Privacy Form
Patient Authorization of Disclosure

Patient Name: **Date:**

In general, the HIPAA Privacy Rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home. The patient may revoke or change this authorization at any time with a written request.

I authorize to be contacted in the following manner:

Primary Phone: _____ Type: ☐ Home ☐ Cell ☐ Work

☐ Yes / ☐ No Leave a voicemail
☐ Yes / ☐ No Receive text messages

Secondary Phone: _____Type: ☐ Home ☐ Cell ☐ Work

☐ Yes / ☐ No Leave a voicemail
☐ Yes / ☐ No Receive text messages

Written Communication

☐ Yes / ☐ No Okay to send mail to my address listed on file
☐ Yes / ☐ No Okay to send emails to my email address on file

☐ **Yes! Send me reminders and useful tips.** This means, we'll remind you when it's time to schedule appointments such as annual hearing tests and routine device performance checks. We will also keep you updated on your warranty information and about advancements in hearing healthcare.

☐ **No,** I do not wish to receive updates informing me of when I am due for appointments, notifications about my warranty expiration, or receive information about advancements in hearing healthcare.

Marketing

☐ **Yes /** ☐ **No** I authorize the use and disclosure of my information to third parties (such as hearing aid manufacturers) for any marketing purposes. I understand that Audiology Concepts may receive financial payment in exchange for making communication on behalf of a third party.

Family Contact

If you wish, we ask that you designate below to whom the staff at Audiology Concepts may discuss your healthcare, scheduling needs, and billing.

☐ Only disclose information to myself

Name:_____ Relationship:_____ Phone:_____

Name:_____ Relationship:_____ Phone:_____

Patient Signature: _____ **Date: _____**