Glendora Hearing Aids & Audiology

Patient Consent for Use and Disclosure
Of Protected Health Information

I hereby give my consent for **Glendora Hearing Aids & Audiology** to use and disclose protected health information (*PHI*) about me to carry out ***treatment, payment*** and ***health care operations (TPO).***

I have the right to review the Notice of Privacy Practice prior to signing this consent.

- **Glendora Hearing Aids & Audiology** reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to **Glendora Hearing Aids & Audiology**.

- With this consent, **Glendora Hearing Aids & Audiology** may call my home or other alternative location and leave a message on voicemail or in person with reference to any items that assist the practice in carrying out *TPO*, such as appointment reminders, insurance items, and any calls pertaining to my clinical care, including test results, among others.

- With this consent, **Glendora Hearing Aids & Audiology** may mail to my home or other alternative location any items that assist the practice in carrying out *TPO*, such as appointment reminder cards and patient statements.

- With this consent, **Glendora Hearing Aids & Audiology** may e-mail to my home or other alternative location any items that assist the practice in carrying out *TPO*, such as appointment reminder cards and patient statements

- I have the right to request that **Glendora Hearing Aids & Audiology** restrict how it uses or disclose my *PHI* to carry out *TPO*. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement

- By signing this form I am consenting to allow **Glendora Hearing Aids & Audiology** to use and disclose my *PHI* to carry out *TPO*.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke, **Glendora Hearing Aids & Audiology** my decline to provide treatment to me.

_____ _____
Signature of Patient or Legal Guardian Print Patient's Name

_____ _____
Date Print Name of Parent or Legal Guardian (if applicable)