

PREMIUM HEARING SOLUTIONS

**PATIENT CONSENT FOR USE AND DISCLOSURE
OF PROTECTED HEALTH INFORMATION**

I hereby give my consent for Premium Hearing Solutions to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). (Premium Hearing Solutions’s Notice of Privacy Practices provides a more complete description of such uses and disclosures.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Premium Hearing Solutions reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Premium Hearing Solutions Privacy Official at **555 W. 14 Mile Road, Suite 2A, Clawson, MI 48017.**

With this consent, Premium Hearing Solutions may call my home or other alternative location and leave a message on voice mail or in person in 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 repaired/ordered hearing products.

With this consent, Premium Hearing Solutions 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 as long as they are marked Personal and Confidential.

With this consent, Premium Hearing Solutions may e-mail to my home or other alternative location any items that assist the practice in carrying out TP using an unsecured email, such as appointment reminder cards and patient statements.

I have the right to request that Premium Hearing Solutions restrict how it uses or discloses my PHI to carry out TPO. However, 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 Premium Hearing Solutions’s use and disclosure of 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 it, Premium Hearing Solutions may decline to provide treatment to me.

Print name of Patient or Legal Guardian

Date

Signature of Patient or Legal Guardian