Hearing Resource Center of San Mateo

NOTICE OF PRIVACY PRACTICES

We are required by law to provide individuals with a notice of our legal duties and privacy practices with respect to your protected health information. Your signature below does not imply agreement with these practices; it is only an acknowledgement that you have been offered a copy of the Notice of Privacy Practices.

I agree that a photocopy of this signed form is as valid as the original.

_____ _____

Patient Signature Date

If not signed by the patient, please indicate:

☐ Parent or legal guardian of minor patient ☐ Guardian or conservator of incompetent patient

☐ Beneficiary or personal representative of deceased patient

CONSENT TO RELEASE HEALTH INFORMATION

Please list your preferred method of contact and check ALL of the methods that the Hearing Resource Center may use to contact you.

Preferred method of contact: _____

Check ALL methods we may use to contact you:

☐ Home Phone ☐ Work Phone ☐ Cell Phone ☐ E-mail ☐ Other: _____

Hearing Resource Center of San Mateo: ☐ May ☐ May Not
leave detailed messages regarding appointment times, test results, treatment recommendations and hearing aid information.

CONSENT TO RELEASE HEALTH INFORMATION TO OTHER NAMED PARTIES

In addition to our normal operational disclosures of privacy information please identify to whom we may release your healthcare information (e.g., spouse, sibling, child, friend, etc,). These should be people who help you with your healthcare needs and may need to be knowledgeable about your conditions, treatment and options. We will not release your healthcare information to family members or other individuals that are not included on this list unless required to do so by law. It is still the responsibility of the below named parties to request information.

Name(s) Relationship

_____ _____

_____ _____

_____ _____

_____ _____