Hear Well Again Centers
800-879-3432/610-359-0200/215-654-5395
fax 610-356-6180

NOTICE OF PRIVACY PRACTICES CONSENT

I consent to the use or disclosure of my protected health information by HEAR WELL AGAIN CENTERS for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care and to conduct health care operations at HEAR WELL AGIN CENTERS. I understand treatment of me by HEAR WELL AGAIN CENTERS may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information may be disclosed to carry out treatment, payment or healthcare operations of the practice. HEAR WELL AGAIN CENTERS is not required to agree to the restrictions that I may request. However, if HEAR WELL AGAIN CENTES agrees to a restriction that I request, it is binding on all employees of HEAR WELL AGAIN CENTERS.

I have the right to revoke this consent, in writing, at any time, except to the extent that HEAR WELL AGAIN CENTERS has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information collected from me and created or received by my physician and/or another health care provider. This protected health information relates to my present or future physical condition and identifies me, or there is a reasonable assumption that the information may identify me.

I understand I have a right to review HEAR WELL AGAIN CENTERS' Notice of Privacy Practices before signing this document. The HEAR WELL AGAIN CENTERS' Notice of Privacy Practices has been offered to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment of my bills or in the daily operations of HEAR WELL AGAIN CENTERS. The Notice of Privacy Practices describes my rights and HEAR WELL AGAIN CENTERS' duties to my protected health information.

HEAR WELL AGAIN CENTERS reserves the right to change the privacy practices that are stated in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a copy of the revision or obtaining one at my next visit.

_____ _____

Signature of Patient or Personal Representative | Name of Patient or Personal Representative (print)

_____ _____

Date | Description of Personal Representative's Authority