RELEASE OF INFORMATION

I agree to have my medical information released to family members or caregiver listed below: such as appointment reminder calls or hearing aid servicing information.

_____

Name of Family Member or Caregiver Relationship to Patient

_____

Name of Family Member or Caregiver Relationship to Patient

Please read carefully and sign below.

- I give permission to Hearing Advantage, Inc. to release information, verbal and written (contained in my medical record and other related information), to my insurance company, case manage, attorney, employer, related healthcare providers, assignees and /or beneficiaries, and all other related persons. Information without patient identifiers may be used for quality purposes.
- I authorize Hearing Advantage to use my protected health information, i.e., my contact information for educational materials and marketing related to hearing healthcare products or services.
- I understand that the practice may receive financial remuneration in exchange for making the marketing communication from or on behalf of the third party whose product or service is being described. I understand that this marketing authorization is in effect until a revocation is received by the practice
- I acknowledge that I may ask for and receive a copy of the Health Insurance Portability & Accountability Act (HIPPA) policy of this office.
- I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for professional services or purchases rendered.
- I have read all the information on this sheet, completed the above answers, and certify this information is true and correct to the best of my knowledge, and hereby give my hearing care provider permission to treat may concerns.

_____ _____

(Signature of patient or legal guardian) (Date)

_____ _____

(Print name signed on behalf of patient) (Relationship to patient)