HIPPA Client Consent of Disclosure

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health/hearing information may be disclosed or used for treatment, payment or healthcare operations.
- The practice reserves that right to change the privacy practice as allowed by law.
- The practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we call, email or text you to confirm appointments? Y N

Texting Number: _____

Email Address : _____

May we leave a message on your answering machine? Y N

May we discuss your health/hearing with any member of your family? Y N

If YES, please name the members: _____

Privacy Practice

By signing this form, I hereby acknowledge that I have been given the option to review or obtain a copy of the Privacy Practices for Hearing Depot, LLC.

Medical Waiver

By signing this form, I have been advised by **Hearing Depot, LLC** that the Food and Drug Administration has determined that my best interest would be served if I had a medical evaluation by a licensed physician (preferably by a physician who specializes in diseases of the ear) before purchasing a hearing instrument. This test information shall be compiled for the purpose of making selections and adaptations of a hearing instrument. I am at least 18 years of age.

Signature _____ **Date** _____