HART HEARING CENTERS
Acknowledgement of Notice Receipt Consent Form

New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Hearing Healthcare Operations

I, _____, understand that as part of my health care, Hart Hearing Centers originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have received a Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that Heart Hearing Centers is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Hart Hearing Centers reserves the right to change this notice and practices prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Hart Hearing Centers change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, email).

I authorize the following persons to have access to my health information:
_____
_____
_____

I understand that as part of this organization's treatment, payment, or health care operations, it may be necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I also agree to have Hart Hearing Centers contact me by letter or telephone to remind me of appointments, hearing aid repairs and other services provided by Hart Hearing Centers.

I also consent to receive marketing materials and company newsletters or other information regarding my healthcare sent to me.

I fully understand and accept the terms of this consent.

_____	_____	_____
Patient's signature	Date	Telephone number

If not signed by patient, please indicate relationship:

____ Parent of guardian of minor patient
____ Guardian or conservator of an incompetent patient
____ Beneficiary or personal representative of deceased patient

Name of patient: _____