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| **Consent to Treatment, Authorization and Medical Release** | A close-up of a sign  Description automatically generated |
| **Serving Arizona, New Mexico, and Texas** | |

*This notice describes how medical information about you may be used, disclosed and how you can get access to this information. Please review it carefully.*

I authorize National Hearing & Balance to give me reasonable and proper medical care by todays standards.

I consent to National Hearing & Balance’s use and disclosure of all individually identifiable personal health, financial and demographic information (known as protected health information of PHI) for the purpose of:

* Providing medical treatment
* Obtaining payment and reimbursement
* Requesting authorization from other providers
* Cooperating with other providers in my medical treatment
* Fulfilling requests for information when specifically authorized by me
* Doing all things directly related to providing healthcare to me
* Communication and promoting all locations and services available through National Hearing and Balance.

The above purpose and all other uses are known collectively as treatment, payment and other healthcare operations, or TPO. I authorize any provider or healthcare facility to provide upon request any PHI to National Hearing & Balance when needed for the purpose of TPO. I authorize release of my medical records to National Hearing and Balance including human immunodeficiency viruses.

Send to National Hearing & Balance discussing any or all of my medical care, including my evaluation, treatment and diagnosis, even if related to psychosocial impairments, substance abuse, human immunodeficiency virus (HIV), HIV-related opportunistic infections, pregnancy, billing or appointments, with the following person(s):

Please list responsible person(s) that we can release your information to, in the event you are not able to receive results of any examination ordered by National Hearing & Balance.

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I consent to allow National Hearing and Balance to leave a message on my answering machine or voicemail regarding my appointment, bill, or test results. I also take responsibility for providing enough information for the office staff to contact me efficiently by mail, telephone, and other forms of communication.

My preferred contact phone number is 1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand my rights to restrict the use and disclosure of PHI and to revoke this consent at any time in writing. I understand that I should choose not to consent to the terms and conditions of Nation Hearing & Balance, the practice had the right to and will withhold treatment, except where required by law.

Patient Name (Print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature (or Guardian): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_