The Hearing Teacher, L3C

Marcie V. Brown, Licensed []]]]Audiologist

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We may use and disclose your information for the following purposes:

- ❏ **Treatment**: providing or directing your health services provided by one or more health providers, such as sending your medical record information to a specialist as part of a referral.
- ❏ **Payment:** verifying your coverages, billing and collecting payment for our services and products and seeking reimbursements for services and products. Examples include billing information to a health insurance plan, billing you for deductibles and co-payments and following up on unpaid services.
- ❏ **Health care operations**: the business of running our practice, such as quality assessment and evaluating the quality of care that you receive, such as comparing patient data to improve treatment methods.

We may also be required to disclose your health information by federal, state or local laws, such as for law enforcement in specific circumstances. In any other situation, we will ask for your written authorization before using or disclosing information. You can later revoke that authorization.

We may change our policies at any time. Before we make a significant change in our policies, we will change our notice and provide you with a copy. You may also request a copy of our notice at any time. You also have the following rights to your protected health information. When you present a written request to our office, you may:

- ❏ Place restrictions on our disclosure of you health information to family members, relatives, friends or any other person identified by you. We may disagree with such a restriction, but if we do agree, your limitation of disclosure will be honored.
- ❏ Inspect and copy your protected health information.
- ❏ Request an amendment to your health information.
- ❏ Receive an accounting of the disclosures of your protected health information.
- ❏ Request that your health information be communicated to you in a confidential manner, such as sending mail to an address other than your home.

If you are concerned that we have violated your privacy rights, or disagree with a decision we made about access to your records, please contact us. You may also send a written complaint to the US Department of Health and Human Services. Under no circumstances will you be retaliated against for filing a complaint.

We are required by law to protect the privacy of your information, provide this notice about our information practices, and follow the information practices that are described in this notice.

I understand that I may revoke this consent in writing at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Print Patient Name _____ Date _____

Patient's Signature _____ Date _____

Relationship to patient if patient is unable to sign _____