HIPAA Use and Disclosure

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize the use and disclosure of my protected health information (PHI) to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (e.g. my insurance company)
- The day-to-day healthcare operations of Medical Hearing Associates of Arkansas, LLC (MHAA)

I have been informed of and given the right to review and secure a copy of MHAA's HIPAA Notice of Privacy Practices document. This document contains a more complete description of the uses and disclosures of my PHI and my rights under HIPAA.

I understand that MHAA reserves the right to change the terms of this Notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.
I understand that I have the right to request restrictions on how my PHI is used and disclosed to carry out treatment, payment and health care operations, but that MHAA is not required to agree to these requested restrictions.

I understand that I may revoke this consent, in writing, at any time. I understand that revocation of this authorization will not affect any action the below named entity took in reliance on this authorization before the below named entity received my written notice of revocation.

I authorize MHAA to use and disclose my PHI as set forth above. I understand that this authorization is voluntary and that MHAA cannot condition my treatment, services, etc. on the signing of this authorization.

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Patient Name   Date

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Patient Signature   Date