# PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for CHARLES A. REGER & ASSOCIATES, INC. to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). CHARLES A. REGER & ASSOCIATES, INC'S Notice of Privacy Practices provides a more complete description of such uses and disclosures.

I also hereby give my consent for CHARLES A. REGER & ASSOCIATES, INC. to use and disclose protected health information (PHI) about me for marketing related to audiological/health-related products or services. I understand that CHARLES A. REGER & ASSOCIATES, INC. may receive financial remuneration in exchange for making the marketing communication from or on behalf of the third party whose product or services is being described. I understand that if the person/organization authorized to receive and use the information is not a health plan or health care provider, the disclosed information may no longer be protected by federal privacy regulations.

I have the right to review the Notice of Privacy Practices prior to signing this consent. CHARLES A. REGER & ASSOCIATES, INC. reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Privacy Officer Trish Kaminski at 425 Park Place Circle, Suite 200, Mishawaka, IN 46545.

With this consent, CHARLES A. REGER & ASSOCIATES, INC. may call my home or other alternative location and leave a message on voice mail or in person in reference to any items(s) that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements at long as they are marked Personal and Confidential.

With this consent, CHARLES A. REGER & ASSOCIATES, INC. may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that restrict how it uses or disclosed my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to CHARLES A. REGER & ASSOCIATES, INC'S use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosure in reliance upon my prior consent. If I do not sign this consent, or later revoke it CHARLES A. REGER & ASSOCIATES, INC. may decline to provide treatment/care to me.

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Signature of Patient or Legal Guardian

_____ _____

Patient's name date

_____

Printed Name of Patient or Legal Guardian