Utah Audiology & Hearing

Utah Audiology & Hearing
2041 Sidewinder Drive #1
Park City, UT 84060

Acknowledgment of Receipt of Privacy Practices
Authorization to Use or Disclose Protected Health Information

Last Name: ______________________ **First:** ______________________
Date of Birth: ____
Address: ____________________ **City:** ____________ **State:** ____________
Phone: ( ) ____

This notice describes how the medical/protected health information about you may be used and disclosed by us. It also tells you how you can obtain access to this information.

Summary: By law, we are required to provide you with our Notice of Privacy Practices. This Notice describes how your medical information may be used and disclosed by us. It also tells you how you can obtain access to this information.

We want to assure you that your medical/protected health information is secure with us. This Notice contains information about how we will insure that your information remains private. If you have any questions regarding this Notice, you may contact
Dr. Norman (435) 655-8824.

This office uses and discloses your protected health care information for the following reasons:

- To share with other treating health care providers regarding your health care
- To submit to insurance companies to verify that treatment was rendered
- To determine patient's health care benefits
- To assist in overcoming a language barrier when caring for a patient
- Releasing information required by State of Federal Health law
- Emergency situations
- Appointment reminders to household members or answering machines
- Abuse, neglect or domestic violence

As a patient, you have the following rights:

- The right to inspect and copy your information
- The right to request corrections to your information
- The right to request that your information be restricted
- The right to request confidential communications
- The right to report disclosures of your information
- The right to a paper copy of this Notice

I understand that:

- I may revoke this Authorization at any time by providing my written revocation to the address at the top of this Authorization. My revocation will not apply to information already retained, used, or disclosed in response to this Authorization. Unless sooner revoked, the automatic expiration date of this Authorization will be twenty-four (24) months from the date on which I have last received treatment from the Company. I have a right to receive a copy of this Authorization from the Company.
- This Authorization is voluntary, and the Company may not condition the provision of treatment or payment for my care on my signing this Authorization.
- If the person or entity receiving my protected health information is not a health care provider or health plan covered by federal privacy regulations, my protected health information may be disclosed by such recipients to other individuals or institutions and no longer protected by federal privacy regulations.

By signing below, I hereby authorize the use and/or disclosure of individually identifiable health information, which is called "protected health information" or "PHI" under the Health Insurance Portability and Accountability Act of 1996 or "HIPAA", and/or medical, audiologic or hearing aid records relating to me.

____ ____________________________
Signature of Patient, Parent, or Legal Authorized Representative Date

PRIVACY ACT NOTICE: Medicare does use social security numbers for identification. Utah Audiology & Hearing confidentially maintains your social security number for this use.

Please Initial:

_____I understand that the services of Utah Audiology & Hearing may be rendered by students as part of their training program. The program includes supervision by ASHA certified staff. At times it may be necessary for authorized persons (i.e. students) to observe for instructional purposes.