CEDAR AUDIOLOGY ASSOCIATES, INC.
PATIENT CONSENT FOR USE AND DISCLOSURE
OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Cedar Audiology Associates, Inc. to use and disclose protected health information (PHI) about me to carry out treatment, payment healthcare operations (TPO).

I have the right to review the Notice of Privacy Practices prior to signing this consent. Cedar Audiology Associates, Inc. reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Cedar Audiology Associates, Inc. Privacy Official at 5010 Mayfield Road Suite # 116 Lyndhurst, Ohio 44124.

With this consent, Cedar Audiology 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 that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, Cedar Audiology Associates, Inc. may mail or 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 Cedar Audiology Associates, Inc. restrict how it uses or discloses 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 Cedar Audiology Associates, Inc. use and disclosure of my PHI to carry out TPO.

I consent to Cedar Audiology Associates, Inc. use or disclosure of my PHI for purposes of delivering relevant product and/or technology marketing communication to me. I acknowledge that Cedar Audiology Associates, Inc. may receive financial remuneration from the manufacturer in connection with such communication.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Cedar Audiology Associates, Inc. may decline to provide treatment to me.

I have been offered/received a copy of Cedar Audiology Associates, Inc. Notice of Privacy Practices.

X **Signature of Patient or Legal Guardian** ______________________________

Print Name of Patient or Legal Guardian ______________________________

Date ____________________

Revised 10-01-2013