Roseville Diagnostic Hearing Center, LLC

Verbal Communication and Personal Representative Form

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). The HIPAA rules and regulations are available for review in our lobby, at our front desk and our website at www.rosevillediagnosticchearingcenter.com. You have the right to appoint a family or friend access to, a portion, or all of your protected health information. As required by HIPAA, we must have your permission on file in order to contact you, verbally disclose your health information to others involved in your health care.

Patient Name:_____ **Date of Birth**:_____

Address:_____

Patient or Responsible Person:_____ **Signature**:_____

Relationship to Patient:_____ **Today's Date**:_____

I hereby authorize the staff of Roseville Diagnostic Hearing Center, LLC to communicate with me by:

[ ] **Phone Calls** – Includes all numbers listed by me on the patient registration form.
[ ] **Phone Messages** - Includes answering machines, messages left with recipient and cell phone voice mails
[ ] **Email** – Appointment reminders and follow-up or messages.
[ ] **Mail**- Includes medical records and appointment reminders, billing statements and invoices.
[ ] **Information Materials** – Includes notifications of special events, offers and newsletters specific to Roseville Diagnostic Hearing Center, LLC only.

_____ (initial) I hereby authorize Roseville Diagnostic Hearing Center, LLC to disclose **ALL** of my protected health information to my personal representative. This information will include all clinical information about my health care, billing information pertinent to my health insurance coverage and payment activity for services, demographic information changes to my account. I understand that my appointed representative is not a health care clinician covered by federal privacy regulations. Information given to my representative will no longer be protected by federal privacy regulations.

_____ (initial) I hereby authorize Roseville Diagnostic Hearing Center, LLC to disclose **ONLY** the protected health information listed below. I understand that my appointed representative will only have access to the specific information of my medical records that I choose: **[ ] Test results and treatment notes [ ] Billing information Other:_____**

_____ (initial) **I Do Not wish to designate a personal representative at this time**.

Representative's Full Name: _____ **Date of Birth**:_____

Representative's Contact Number:_____

Representative's Full Name: _____ **Date of Birth**:_____

Representative's Contact Number:_____

Representative's Full Name: _____ **Date of Birth**:_____

Representative's Contact Number:_____

I understand that I have the right to receive a copy of this authorization. I understand that Roseville Diagnostic Hearing Center, LLC reserves the right to request proof of authority for representative acting on the this person's behalf for verification purposes.

A copy of this form is as valid as the original. I may revoke this authorization in writing at any time by written notification to Roseville Diagnostic Hearing Center, LLC. Attn: Privacy Officer/ Roseville Diagnostic Hearing Center, LLC. 1411 Secret Ravine Parkway, Suite 120 Roseville, CA 95661