Roseville Diagnostic Hearing Center, Inc.

Verbal Communication and Personal Representative Form

Acknowledgement of Receipt of Notice of Privacy Practices

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.rosevillediagnostichearingcenter.com. By signing this consent, I authorize this center to use and disclose my protected health information to carry out treatment. 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**:_____

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

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

By Signing this form, I hereby authorize the staff of Roseville Diagnostic Hearing Center, Inc. to communicate with me by: Phone Calls, **Phone Messages**, **Email**, **Mail**, **Information Materials** – Includes notifications of special events, offers and newsletters specific to Roseville Diagnostic Hearing Center, Inc only.

Please Initial One only:

_____ (initial) I hereby authorize Roseville Diagnostic Hearing Center, Inc to disclose **ALL** of my protected health information to my personal representative: includes all clinical and billing information pertinent to my health insurance coverage and payment activity for services, demographic information changes to my account. Information given to my representative will no longer be protected by federal privacy regulations.

_____ (initial) I hereby authorize Roseville Diagnostic Hearing Center, Inc 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**.

Family Member/Representative's Full Name: _____**Date of Birth**:_____

Family Member/Representative's Contact Number:_____

By signing this form, I acknowledge that I have received the Notice of Privacy Practices, have been informed of, and given the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you agree, you are then bound to comply with this restriction.

I understand that I have the right to receive a copy of this authorization. I understand that Roseville Diagnostic Hearing Center, Inc. reserves the right to request proof of authority for representative acting on 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, Inc. Attn: Privacy Officer/ Roseville Diagnostic Hearing Center, Inc. 1411 Secret Ravine Parkway, Suite 120 Roseville, CA 95661

INABILITY TO OBTAIN ACKNOWLEDGEMENT: Complete only if signature cannot be obtained due to:

[ ] The patient is not able to sign the form and there is no legal representative available.

[ ] The patient refuses to sign the acknowledgement of receipt.

Date: _____ Signature of Employee:_____