Island Audiology & Hearing Aid Centers

AudigyCertified™

"Hear Better. Live Better"

PATIENT CONSENT FORM

With my consent and signature, Island Audiology and Hearing Aid Centers may use and disclose protected health information about me or my child to:

- Carry out treatment, payment, and healthcare operations (services).
- Call my home or other designated locations and leave a message on voice mail in reference to any items (i.e. appointment reminders, insurance items, etc.).
- Mail to my home or other designated address any item (i.e. appointment reminder cards, patient financial statements, etc).
- Send or transmit email to any location provided by me for all above similar items and purposes.
- To use and/or disclose protected health information about me or my child to/with third parties involved in mine or my child's care. Such parties may include, but are not limited to, insurance companies, hospitals, and specialty physicians. I may specifically describe the type of information (i.e. dates of services, level of detail, origin of information, etc.) subject to disclosure and may revoke this permission at a time and date chosen by me.

Consent for Audio/Video Recordings/Telehealth Services:
Island Audiology is a training facility that may require audio/video recordings of appointments for quality assurance and training purposes. Telehealth involves transmission of video, photographs, and/or details of my medical record and test results (collectively, "Data"). All Data is sent by secure electronic means to the Providers to facilitate the medical service being performed. I understand that:

- I will be informed of any other people who are present at either end of the telehealth encounter, and have the right to exclude anyone from either location.
- All confidentiality protections required by law or regulation will apply to my care.
- I have the right to refuse or stop participation in telehealth services at any time and request alternate service such as in-person appointment. However, I understand that equivalent in-person services might not be available at the same location or time as telehealth service.
- If I do not want to receive health care services by telehealth, it will not affect my right to future care or treatment, or any insurance/program benefits to which I would otherwise be entitled.

I have the right to review the Notice of Privacy Practices of Island Audiology and Hearing Aid Centers. I may request a copy at any time. I understand that I may request in writing that Island Audiology and Hearing Aid Centers restrict how my or my child's private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand that Island Audiology and Hearing Aid Centers is not required to agree to my requested restrictions. If agreed, then Island Audiology and Hearing Aid Centers is bound to abide by such restrictions.

I may revoke this entire consent, in writing, at any time. If I do not sign this consent, or revoke this consent, Island Audiology and Hearing Aid Centers, may decline further treatment of me or my child.

Patient's Name _____

Signature _____ Date _____

Relationship to Patient ☐ Self ☐ Spouse ☐ Child ☐ Other _____
(please specify)

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