Hearing Solutions, PLLC
CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION (PHI)

This form is to confirm your authorization to use or disclose your Protected Health Information (PHI) for treatment, payment activities and healthcare services at Hearing Solutions, PLLC.
I give my authorization to use or disclose my (PHI) for treatment, payment activities, and healthcare services, allowing Hearing Solutions, PLLC to use or disclose my (PHI) to submit claims to my insurance company and report results to my primary care physician or referring physician.

Patients Name:_____ Social Security #_____
Address: _____
Phone #:_____
Name of Insurance Company:_____

Hearing Solutions, PLLC. provides you with important diagnostic information about your hearing. We feel it is important for your primary care physician or referring physician to have this information for your medical records. By signing this form you are giving us permission to send a copy to your physician. This release will be in effect until we receive a written notice from you requesting that we may no longer forward this information.

Family member and Physician that you authorize to receive your PHI.

Family Members Name: _____Phone #_____
Primary Care or Referring Physicians Name: _____
Name and Address of Practice: _____
Phone number/Fax number: _____

We reserve the right to change our privacy practices as described in our Patient Privacy Statement Policy. If we change our privacy practices, we will issue a revised Patient Privacy Statement Policy with any changes that may apply to your PHI that we maintain.
You may obtain a copy of our Patient Privacy Statement Policy at any time by contacting:
Jean Z. Couchman, Audiologist/Owner, 14408 Sommerville Court, Midlothian, VA. 23113
Phone: 804-794-9087 Fax: 804-794-9089
email: jzcouchman@hearingsolutions.us or ldenise@hearingsolutions.us

Individual Patient's Signature

I have had the opportunity to read and think about the content of this authorization form and I agree with all statements made in the authorization. I understand that, by signing this form, I am confirming my authorization for use and/or disclosure of the Protected Health Information described in this form with the Physician(s) and Insurance Companies named in this form.

Patient Signature _____ **Date** _____