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PATIENT CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION

Clarity Audiology & Hearing Solutions, LLC. obtains and maintains health information relating to your past, present or future physical or mental condition, provision of health care or payment for health care, referred to as "Protected Health Information." This Protected Health Information may be used or disclosed by *Clarity Audiology & Hearing Solutions, LLC.* for purposes of treatment, payment or health care operations, including, but not limited to:

- sending information to your referring health care provider or primary care physician as indicated on my patient intake form;
- planning for my care and treatment;
- calling me with appointment reminders and test results;
- submitting a claim to my insurer or health plan; and
- assessing the quality of care provided to me.

Clarity Audiology & Hearing Solutions, LLC.'s *Notice of Privacy Practices* contains a more complete description of how my Protected Health Information may be used and disclosed and how I can obtain access to this information. I understand that *Clarity Audiology & Hearing Solutions, LLC.* reserves the right to change its *Notice* and practices and I can request a copy of its current *Notice*.

I understand that I have the right to request restrictions as to how my Protected Health Information may be used or disclosed by *Clarity Audiology & Hearing Solutions, LLC.* *Clarity Audiology & Hearing Solutions, LLC.* is not required to agree to my request but if *Clarity Audiology & Hearing Solutions, LLC.* does agree, the requested restrictions will be binding.

I further understand that, at anytime, I may revoke this consent in writing, except to the extent that *Clarity Audiology & Hearing Solutions, LLC.* has already taken action in reliance on it.

By signing this form below, I consent to *Clarity Audiology & Hearing Solutions, LLC.*'s use and disclosure of my Protected Health Information for the purpose of treatment, payment, and/or health care operations and acknowledge that I have received a copy of the Privacy Notice of *Clarity Audiology & Hearing Solutions, LLC.*:

Signature of Patient or Legal Representative

Relationship to patient

Print Name

Date

Witness

By signing this form below, I consent to the disclosure of my Protected Health Information to the designated person(s):

I, (patient's name) _____, **give my permission** to share my PHI (Protected Health Information) with (print designated person's name(s) :

Name Relation

Name Relation

Name Relation

Signature of Patient or Legal Representative Witness Date

By signing this form below, I DO NOT give my permission to share my PHI with anyone other than for the purpose of treatment, payment, and/or health care operations.

Signature of Patient or Legal Representative Witness Date