

ROCHESTER HEARING AND SPEECH CENTER

Consent to Use and Disclose Protected Health Information for Evaluation, Treatment, Payment and Health Care Operations

Name: _____

Date of Birth: _____

(Please print)

I understand that my signature on this consent is required in order for me to receive services from Rochester Hearing and Speech Center. In addition, I authorize the use and disclosure of my Protected Health Information (PHI) by Rochester Hearing and Speech Center’s staff for purpose of evaluation, treatment, payment and health care operations.

I understand that this information may be used or disclosed by Rochester Hearing and Speech Center to

- * plan my care and treatment;
- * communicate among various health care professionals who are involved in my care or treatment;
- * obtain payment for care provided by Rochester Hearing and Speech Center or for the payment activities of another health care provider or entity;
- * provide information to my health insurance company or plan;
- * assess and review the quality of my care. Further information on uses and disclosures of PHI is included in Rochester Hearing and Speech Center’s Notice of Privacy Practices.

As part of RHSC’s comprehensive services, we will release the findings of your reports to those professionals involved in your care. Reports will automatically be sent to the physician listed and to referral sources. To send these reports, we must have your authorization to do so. This authorization will be valid through this specific course of treatment.

Please list any other specific individuals/facilities you would like information shared/sent to. (ex. relatives, day care providers, etc.):

If there are any restrictions, please indicate:

I understand that I may cancel this authorization at any time by submitting a written request and that the release of HIV-related information requires additional authorization.

Payment, excluding that covered by insurance, is due at the time of service. If, for any reason, your insurance refuses to pay us for all or part of the service, you will be billed for the service provided. Payment will be due within 30 days of billing. If payment is not received within 30 days, your account will be forwarded to a collection agent, and further services will not be provided until your account is satisfied.

Parent or Legal Guardian *(Print)*

Date

Signature

Relationship