

HIPAA AUTHORIZATION & PRIVACY ACKNOWLEDGMENT FORM

Patient Information

Patient Name: _____ Date of Birth: _____

I. Authorization to Release Medical Information

I authorize Abram Audiology to release or disclose my PHI, including audiological evaluation results, diagnoses and treatment information, to the following: (Check all that apply)

- ☐ Primary Care Physician: _____
- ☐ ENT/Otolaryngologist: _____
- ☐ Insurance Provider(s) for Claims/Payment Purposes
- ☐ Family Member(s): _____ (Name and Relationship)
- ☐ Other: _____

This authorization:

- Does not expire unless otherwise specified: _____
- May be revoked in writing at any time, except to the extent that action has already been taken in reliance on this authorization
- Will not be used for purposes other than those stated above without my written permission, unless required or permitted by law

II. Communication Preferences

I authorize Abram Audiology to contact me regarding appointments, results and billing via: (Check all that apply)

- ☐ Phone Call: _____ ☐ Voicemail ☐ Text Message
- ☐ Email: _____
- ☐ Preferred Contact Method: _____

III. Notice of Privacy Practices Acknowledgment

This Notice describes how medical information about you may be used and disclosed, and how you can get access to this information. Please review it carefully.

Our Responsibilities

Under the Health Insurance Portability and Accountability Act (HIPAA), we are required to:

- Maintain the privacy of your protected health information (PHI)
- Provide you with this Notice explaining our legal duties and privacy practices
- Notify you in the event of a breach of your unsecured PHI
- Follow the terms of this Notice

How We May Use and Disclose Your PHI

We may use or share your PHI without your written authorization in the following ways:

1. For Treatment

We may use your PHI to provide audiology services, coordinate care with other health care providers and share results (such as audiograms or hearing aid fitting data) with your physician or other specialists.

2. For Payment

We may use and disclose your PHI to bill and collect payment from you, your insurance company or a third party.

3. For Health Care Operations

We may use your PHI for quality improvement, staff training, business management and accreditation purposes.

4. When Required by Law

We will disclose PHI when required by federal, state or local law.

5. Public Health and Safety

We may share PHI to prevent or control disease, report abuse or neglect or to avoid a serious threat to health or safety.

Other Uses and Disclosures With Your Written Authorization

In all other situations, we will obtain your written permission before using or disclosing your PHI. You may revoke this authorization at any time in writing.

Changes to This Notice

We reserve the right to change this Notice at any time. The revised Notice will be posted in our office and available upon request.

Questions or Complaints

If you have questions or believe your privacy rights have been violated, you may contact our privacy officer:

Privacy Officer: Jackie Abram

Address: 908 Eighth St., West Des Moines, IA 50265

Phone: 515-581-9279

Email: staff@abramaudiology.com

You may also file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you for filing a complaint.

Your Rights

You have the right to:

- Access your medical records and request copies
- Request amendments to incorrect or incomplete PHI
- Request restrictions on how we use or disclose your PHI (we are not required to agree, but we will comply when possible)
- Request confidential communications (e.g., to be contacted at a different phone number or address)
- Receive an accounting of disclosures of your PHI made in the past six years, excluding those for treatment, payment and health care operations
- Receive a paper copy of this Notice, even if you have agreed to receive it electronically

IV. Patient Rights & Acknowledgments

- I understand I have the right to inspect and obtain a copy of my medical records.
- I understand that HIPAA allows disclosure of PHI without authorization in certain cases (e.g., public health requirements, legal obligations).
- I understand that Abram Audiology will take reasonable safeguards to protect my PHI, but it cannot guarantee absolute confidentiality of email or text communication.

Signature

Patient or Legal Representative: _____

Relationship to Patient (If Applicable): _____

Date: _____ Staff Witness Initial/Date: _____