Locations
723 Superior St. • Antigo, WI 54409• P: 715-627-4199
2801 E. Main St #5 • Merrill, WI 54452 • P: 715-536-0010
205 N. Shawano St. • New London, WI 54961 • P: 920-982-3313
#10 9th St. • Clintonville, WI 54961 • P: 715-823-1397
1056 E Green Bay St. • Shawano, WI 54166 • P: 715-542-4242
213 N. Main St. • Waupaca, WI 54981 • P: 715-258-0088

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

☐ By checking this box and signing below, I acknowledge that I received a copy of Hearing Services or Wisconsin Notice of Privacy Practices. The Notice provides information about how we may use and disclose the medical information that we maintain about you. We encourage you to read the full Notice. I understand that a copy of the current Notice will be posted in the reception area, the website (if applicable) and that any revised Notice of Privacy Practices will be made available.

_____ _____
Printed name of patient or personal representative Date

_____ _____
Signature of patient or personal representative Date

Page 2 "Disclosure of Health Information" is where you can list your doctor, spouse, children, etc. or anyone who can call and talk to us on your behalf.

You can also prohibit all.

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On Page 3, please sign, date, and pick an expiration date (default is 1 year unless you chose otherwise i.e. 2 years, 5 years,

Page 4, titles "Information for Marketing" if you consent it gives Hearing Services of Wisconsin the right to notify you via mail about your appointments, hearing aids, warranty expirations, and promotions.
We do not sell your information to others.

On Page 5, please sign, date, and pick an expiration date (default is 1 year unless you chose otherwise i.e. 2 years, 5 years, forever).

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Authorization to Use and Disclosure of Health Information

Patient Name: _____ Date of Birth: _____

Address: _____ City/State/Zip: _____

Social Security #: _____ Phone #: _____

I request and authorize Hearing Services of Wisconsin to disclose my protected health information as described below. I understand that if the person/organization authorized to receive and use the information is not a health plan or health care provider, the disclosed information may no longer be protected by federal privacy regulations.

· I consent to Hearing Services of Wisconsin releasing protected health as detailed below.

· I Prohibit Hearing Services of Wisconsin from using and disclosing medical information to any person or entity other than required by HIPAA regulations.

My protected health information may be used or disclosed to the following:

_____

_____

For the Purpose of: _____

_____

If you need assistance in completing the authorization form, please contact Thomas Parry at Tparry@hearingserviceswi.com

I understand that I have the right to request restrictions as to how my protected health information may be used or disclosed by Hearing Services of Wisconsin.

I understand that this authorization is in effect until the revocation section of this form is signed or until written notice of revocation is received. I may revoke this authorization at any time by signing the revocation section of my copy of this form and returning it to Hearing Services of Wisconsin.

HEARING SERVICES OF WISCONSIN

Locations
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HIPPA FORM Authorization to Use and Disclosure of Health Information

I authorize Hearing Services of Wisconsin's use and disclosure of my protected health information as set forth above. I understand that this authorization is voluntary and that Hearing Services of Wisconsin cannot condition my treatment, services, etc… on the signing of this authorization. I understand that if I am signing on behalf of a minor child, this authorization will expire upon the child reaching the age of 18, unless there is proof of legal guardianship.

_____ _____
Printed name of patient or personal representative Date

_____ _____
Signature of patient or personal representative Date

EXPIRATION SECTION

Expiration: This authorization will expire on (must choose one):

- One year from the date it is signed
- Other (insert date or event): _____

REVOCATION SECTION

Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice to the address listed at the bottom of this form. I understand that revocation of this authorization will not affect any action the above named entity took in reliance on this authorization before the above named entity received my written notice of revocation.
I hereby revoke this authorization.

_____ _____ _____
Printed name of patient or personal representative Date

_____ _____ _____
Signature of patient or personal representative Date

HEARING SERVICES OF WISCONSIN

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HIPPA FORM Authorization to Use and Disclosure of Health Information

Authorization and Release for the Use and/or Disclosure of Protected Health Information for Marketing

Patient Name: Date of Birth:

Address: City/State/Zip

Social Security #: Phone #:

I authorize Hearing Services of Wisconsin to use/disclose my protected health information for marketing related to audiological/health-related products or services. I understand that Hearing Services of Wisconsin or its business associates may receive financial remuneration in exchange for making the marketing communication from or on behalf of the third party whose product or service is being described.

I understand that if the person/organization authorized to receive and use the information is not a health plan or health care provider, the disclosed information may no longer be protected by federal privacy regulations.

• I Authorize Hearing Services of Wisconsin to use and disclose medical information for any and all marketing purposes and understand that Hearing Services of Wisconsin or its business associate may receive financial remuneration in exchange for making the marketing communication for on behalf of the third party whose product or service is being described. A list of anticipated and potential persons/class of persons/organizations to whom information may be disclosed is included below.

• I request an Authorization form for each instance Hearing Services of Wisconsin intends to use and disclose medical information for any marketing purposes and understand that Hearing Services of Wisconsin or its business associate may receive financial remuneration in exchange for making the marketing communication or on behalf of the third party whose product or service is being described.

• I prohibit Hearing Services of Wisconsin from using and disclosing medical information for any marketing purposes.

A list of anticipated and/or potential persons/class of persons/organizations to whom information may be disclosed:

If you need assistance in completing the authorization form, please contact Thomas Parry at Tparry@hearingserviceswi.com.

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I understand that I have the right to request restrictions as to how my protected health information may be used or disclosed by Hearing Services of Wisconsin.

I understand that this authorization is in effect for the term set forth below or until the revocation section of this form is signed and received. I may revoke this authorization at any time by signing the revocation section of my copy of this form and returning it to Hearing Services of Wisconsin.

I authorize Hearing Services of Wisconsin's use and disclosure of my protected health information as set forth above. I understand that this authorization is voluntary and that Hearing Services of Wisconsin cannot condition my treatment, services, etc… on the signing of this authorization. I understand that if I am signing on behalf of a minor child, this authorization will expire upon the child reaching the age of 18, unless there is proof of legal guardianship.

_____ _____
Printed name of patient or personal representative Date

_____ _____
Signature of patient or personal representative Date

EXPIRATION SECTION

Expiration: This authorization will expire on (must choose one):

- One year from the date it is signed
- Other (insert date or event):

_____

REVOKE SECTION

Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice to the address listed at the bottom of this form. I understand that revocation of this authorization will not affect any action the above named entity took in reliance on this authorization before the above named entity received my written notice of revocation.

I hereby revoke this authorization.

_____ _____
Printed name of patient or personal representative Date

_____ _____
Signature of patient or personal representative Date