KAW VALLEY HEARING

1520 Wakarusa Drive
Suite B
Lawrence, KS 66047
www.kawvalleyhearing.com

PATIENT HIPAA CONSENT FORM / NOTICES OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice such as quality assessments and audiologist certifications.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA.

_____
Patient Name (Printed)

_____ _____ _____
Patient/Guardian Signature Date

AUTHORIZATION FOR HEALTH CARE MARKETING COMMUNICATIONS

Kaw Valley Hearing, LLC values you as a patient and respects the privacy of your personal and medical information that is disclosed to us in the course of our treatment relationship with you. The law allows us to send written communications to you about treatment and health care operations, including products and services we offer. This is a normal part of our provider-patient relationship, and no permission is required for us to do so. We believe such communications are a valuable part of our relationship with you. ***However***, certain types of communications cannot be sent to you unless you provide written authorization to receive them: communications that are sponsored or reimbursed by a third party whose hearing health care products, services or therapies, including hearing aids, are promoted in the communications being sent to patients. *You have a choice whether to receive these communications.*

Please check one box below and add your initials to indicate whether you authorize the health care marketing communications described herein.

☐ I authorize _____ ☐ I *do not* authorize _____

Kaw Valley Hearing, LLC to use or disclose my name, mailing address, or email address for the purpose of sending me materials that market or promote hearing health care products, services or therapies, including hearing aids, for which XYZ Business may receive direct or indirect payment from the third-party hearing health care company whose products or services are being promoted in such communications.

I understand that I have the right to revoke this authorization in writing at any time by sending written notification to Kaw Valley Hearing, LLC at 1520 Wakarusa Drive, Suite B – Lawrence, KS 66047. I understand that a revocation is not effective to the extent Kaw Valley Hearing, LLC has already relied on the authorization to use or disclose my health information as described above. This authorization will remain in effect for a period of 2 year(s) unless revoked in writing.

_____ _____ _____
Patient/Guardian Signature Date

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below.

_____ _____ _____
DATE INITIALS REASON