Elena L. Maresca Au.D.
Hearing and Tinnitus Management
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AUTHORIZATION FOR RELEASE / HIPAA

My **"protected health information"** means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse.

AUTHORIZATION FOR RELEASE OF INFORMATION, FOR POURPOSES OF CONTINUITY OF CARE

I consent to the use or disclosure of my protected health information by Hearing and Tinnitus Management and its staff for the purpose of diagnosing or providing treatment to me. I understand that my test results will be forwarded to my primary care physician, ear nose and throat physician and referring physician for continuity of care. I understand I have the right to request a restriction as to how my protected health information is used or disclosed. I have the right to revoke this consent, in writing, at any time.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative Date

AUTHORIZATION FOR RELEASE OF INFORMATION, FOR PUROPSES OF PAYMENT

I consent to the use or disclosure of my protected health information by Hearing and Tinnitus Management and its staff for the purpose of obtaining payment for my health care bills. I understand I have the right to request a restriction as to how my protected health information is used or disclosed. I have the right to revoke this consent, in writing, at any time.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative Date

ASSIGNMENT OF BENEFIT

I hereby assign/transfer any payments/benefits to which I may be entitled to, from government agencies, insurance companies or others parties who are financially liable for my medical treatment. I understand that I am financially responsible for any services not covered by my insurance company.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative Date

NOTIFICATION PERMISSION

We may need to contact you to confirm your appointment, return your phone calls, or to deliver information about health-related services. Contact from this office may be in the form of letters, newsletters, telephone or cell phone, fax, answering machine, emails or voice mail.

May we leave a voicemail recording on your home telephone?	YES	NO
May we leave a voicemail recording on your cell phone?	YES	NO
May we leave a voicemail recording on your work phone?	YES	NO
May we use electronic communication (e-mail, fax) to transmit information for continuity of care and payment reimbursement?	YES	NO
May we speak with another individual regarding your healthcare?	YES	NO

Please state the name if any of the significant other whom which you would allow us to speak with regarding your medical treatment. _____

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative Date