Peninsula
HEARING SERVICES

Patient Consent Form

Pursuant to the information provided in the Notice of Privacy Practices, I acknowledge being provided with Peninsula Hearing Services "Notice of Privacy Practices" and give permission for the use and disclosure of Protected Health Information (PHI) in order to carry out Treatment, Payment and Hearing Health Procedures.

I am aware that I have the right to review the Notice of Privacy Practices prior to signing the consent. Should the Notice of Privacy Practices be revised, I am aware that I may obtain a copy of the revised form by contacting Dr. Folmar directly.

I give my consent for Peninsula Hearing Services and its associated billing/claims representatives to contact me using the contact information I provide and consent to the use of mail, e-mail and/or leaving a message through voicemail or with another person regarding any matter which will help me with Treatment, Payment and Hearing/Balance Care Procedures.

I hereby consent to the use and disclosure of my PHI for the purposes of Treatment, Payment and Hearing Care Procedures. This consent is good until revoked in writing, except to the extent that disclosures have been made in reliance upon my prior consent.

Services are provided without regard to sex, race, color, religion, national origin or disability.

I confirm that I understand this form and the information contained therein, I am a native speaker of English or have an interpreter with me who has explained the information in my native language.

_____ _____

Print Name Date

_____

Signature

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