HIPPA Statement of Understanding

If you would like to allow someone else (parents, a spouse, caretakers, etc.) to have access to your medical information, you must indicate that on this form.

Is there anyone you would like to have access to your medical information? YES NO

If yes, please list names and their relationship to you here:

_____

_____

Please INITIAL the following statements to indicate you have read and understand them.

_____ By signing below you agree that the above information has been provided by you and is correct and complete. You understand this information will only be used for your personal medical record in the office of Greenbrier Audiology. The above information you have provided will not be sold and will not be shared for any purpose other than further medical treatment or care.

_____By signing below you agree you have read and understand the HIPAA notice of privacy policy that we follow in our practice. You understand we only provide your medical information to individuals you have listed above, or to providers including other doctors. You may specify any further instructions on this form.

_____By signing below you acknowledge this form may be modified and re-submitted by you at any time. Once this form is signed and submitted it becomes part of your permanent record and will be effective until you make changes or until the time of your death.

If you have questions about this information or form, please ask to speak to Laura Stout, Au.D. At 304-647-4327 (Lewisburg Office) or 304-255-6310 (Beckley Office).

Patient printed name_____

Patient signature_____Date_____

Staff signature_____Date_____