**Anderson-Oconee Speech & Hearing Services**

**106 Dostak Drive**
**Anderson, SC 29621**

**409 E.N. First Street**
**Seneca, SC 29678**

**Patient Name:** _____

**Insurance Information**

**Employee Name** _____ **Name of Insurance Co** _____
**Date of Birth** _____ **Address** _____
**Relationship to Patient** _____ _____
**Employer Name** _____ **Telephone** _____
**Social Security Number** _____ **Alternate ID** _____ **Group #** _____

**Authorization for Use and/or Disclosure of Health Information/Release of Information**

**Persons Authorized to Make the Use and/or Disclosure: Anderson-Oconee Speech & Hearing Services and their employees.**
**Persons to Whom the Use and/or Disclosure May be made:**

□ **Physician(s)**
**Name and address of physician:** _____

□ **Other:** _____

- **I understand that if the person or entity that receives this information is not a health care provider or health plan covered by HIPAA, the released information may be re-disclosed by the recipient and may no longer be protected by federal or state law.**
- **I understand that this Authorization for Use and Disclosure expires five years from the date of the authorization listed below. After the expiration date, all additional uses and disclosures would require that a new Authorization for Use and Disclosure be completed.**
- **I understand that I may revoke this authorization, at any time, by notifying Anderson-Oconee Speech & Hearing Services in writing. I understand though that if I do so, this revocation will not affect or apply to any actions taken by Anderson-Oconee Speech & Hearing Services before receiving my revocation.**

□ **By checking this box and signing below, I hereby acknowledge that I have received and read the Anderson-Oconee Speech & Hearing Services Notice of Privacy Practices, Policies, and Procedures and that I understand my rights and responsibilities as outlined by this document.**

□ **By checking this box and signing below, you allow Anderson-Oconee Speech & Hearing Services to release all medical information to your insurance carrier(s). You also agree to accept financial responsibility for all charges which are non-covered and thus not paid to Anderson-Oconee Speech & Hearing Services by your insurance carrier(s) for services rendered by our office. This release is valid for life but may be revoked, in writing at any time. Refusal to sign or revocation of this release will result in you being financially responsible for payment in full at the time of visit.**

□ **By checking this box and signing below, I hereby authorize Anderson-Oconee Speech & Hearing Services to use and/or disclose my protected health information as outlined by the Health Insurance Portability and Accountability Act of 1996 for marketing purposes by Hearing Services and Hearing Aid Center, Inc and Anderson-Oconee Speech & Hearing Services may receive either direct or indirect compensation for doing so.**

**By signing below, I hereby authorize the use and/or disclosure of individually identifiable health information, which is called "protected health information" or "PHI" under the Health Insurance Portability and Accountability Act of 1996 or "HIPAA", and/or medical, audiology, speech or hearing aid records relating to me.**

**Date:** _____

**Print Name of Patient:** _____ **Patient's Date of Birth:** _____

**Signature of Patient:** _____

**<u>For Patient's Parent or Guardian, if applicable:</u>**

**Print Name of Parent or Guardian:** _____ **Describe relationship to Patient:** _____

**Signature of Parent or Guardian:** _____