Understanding Your Hearing Health Record and Information

Each time you visit a hospital, physician, or other healthcare provider, a record of your visit is made. Your medical information is personal. We are committed to protecting your medical information. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, plan for future care or treatment, demographics, and health insurance information.

We refer to this information as your medical record. We need this information to provide you with quality care and to comply with certain legal requirements. We use this information for planning your care and treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care you receive. In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you.

If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures. Understanding what is in your record and how your health information is used helps you to ensure its accuracy, better understand who, what, when, where, and why others may access your health information and make more informed decisions when authorizing disclosures to others.

How this office may use and disclose your Medical Information

There are other ways your medical information may be used or disclosed beyond treatment, payment, and administrative purposes as noted in the above section. The following describes the different ways that your medical information may be used or disclosed by this office. Not every possible use or disclosure is specifically mentioned.

Appointment Reminders
We may use and disclose information as a reminder to you that you have an appointment at this office. We currently use methods of answering machines, letters, postcards and newsletters sent through the mail to include recommended upgrades and or promotional material.

As Required By Law
We will disclose medical information about you when required to do so by federal, state, or local law.

To Avert a Serious Threat to Health or Safety
We may use or disclose medical information to someone able to help prevent or treat when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Law Enforcement
We may release medical information about you if required by law when asked to do so by a law enforcement official.

Individual Rights
In most cases, you have the right to look at or get a copy of health information about you that we use to make decisions about you. If you request copies, we may charge you $0.25 for each page and a fee of $15.00 for the time involved. You also have the right to receive a list of instances where we have disclosed health information about you for reasons other than treatment, payment, or related administrative purposes. If you believe that information in your record is incorrect or if important information is missing, you have the right to request that we correct the existing information or add the missing information. If you request a copy or to review your medical record, we will respond within 30 days of receipt of notice.

You may request in writing that we not use or disclose your information on treatment, payment, and administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances. We will consider your request but are not legally required to accept it.

Complaints
If you are concerned that we have violated your privacy rights, or if you disagree with a decision we made about access to your records, you may contact our Privacy Official or Administrator. You also may send a written complaint to the U.S. Department of Health and Human Services. The Privacy Official or Administrator can provide you with the appropriate address upon request.

Our Legal Duty
We are required by law to protect the privacy of your information, provide this notice about our information practices, and follow the information practices that are described in this notice and in our policies.

Acknowledgement
I acknowledge receipt of this notice of information practices. I understand that I may request additional restrictions on the use and disclosure of my protected health information or for additional confidential treatment of communications.

Signature_____ Date_____

If you have any questions or complaints, please contact

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