Drs. Hodgson, Lewis, Hertler & Kim
Audiology Associates

I authorize Drs. Hodgson, Lewis, Hertler & Kim, and Audiology Associates **to use and disclose** the health and medical information of (patient name) _____ For the purposes of **treatment, payment and health care operations.**

Treatment includes activities performed by a physician, nurse, office staff, and other types of health care professionals providing care to you, coordinating or managing your care with third parties, and consultations with and between other health care providers. This consent includes treatment provided by any physician who covers my/our practice by telephone as the on-call physician.

Payment includes activities involved in determining your eligibility for health plan coverage, billing and receiving payment for your health benefit claims, and utilization management activities which may include review of health care services for medical necessity, justification of charges, precertification and preauthorizations.

Health Care Operation includes the necessary administrative and business functions of our office.

You may review Drs. Hodgson, Lewis, Hertler & Kim, and Audiology Associates **"Notice of Privacy Practices"** for additional information about the uses and disclosures of information described in this CONSENT prior to signing this CONSENT. Please verify that you have received a copy of our **Notice**: _____ (please initial).

Because we have reserved the right to change our privacy practices in accordance with the law, the terms contained in the **Notice** may change also. A summary of the **Notice** will be posted in the lobby of our office indicating the effective date of the **Notice** in the upper right hand corner. We will offer you a copy of the **Notice** on your first visit to us after the effect e date of the then current **Notice**. We will also provide you with a copy of the **Notice** upon you request.

As more fully explained in the **Notice**, you have the right to request restrictions on how we use and disclose your protected health information for treatment, payment, and health care operations purposes. We are not required to agree to your request. If we no agree, we are required to comply with your request unless the information is needed to provide you emergency treatment. Other physicians who provide call coverage for our office are required to use and disclose your protected health information consistent with the **Notice**.

I understand that I have the right to revoke the CONSENT provided that I do so *in writing,* except to the extent that Drs. Hodgson, Lewis, Hertler & Kim, and Audiology Associates have already used or disclosed the information in compliance of this CONSENT.

_____ _____ OR
Date Signature of Patient

_____ _____
Date Signature of Person Authorized by Law