Erie Audiology, Inc.
HIPAA COMPLIANCE FORM

Name:____ Date of Birth:____/____/______

Physical Address:__________________________________City________________State____ZIP______

☐ HOME PHONE: (_____)____________________ ☐ CELL PHONE: (_____)__________________________

☐ WORK PHONE: (_____)____________________ ☐ EMAIL:_________________________________

Please provide us with a list of contacts that we may share your information with, if need be, in order to provide you with appropriate care. By allowing us to share your information, we will be authorized to provide your approved contacts with copies of your hearing tests, to request us to fax copies of your hearing tests to specified physicians or appropriate facilities, and to discuss with them the appropriate care for your type of hearing loss and care of your hearing aid(s).

Please follow the examples provided:

Contact: Jane Doe — **relationship: / Ph: # Daughter 814-123-4567**
Contact: John Smith — **relationship: /Ph: # Son 814-123-4567**
Contact: Dr. XYZ — **relationship: /Ph: # Family Doctor 814-123-4567**
Contact: ABC — **relationship: /Ph: # Friend/Caregiver 814-123-4567**

Contact	Relationship / Ph: Number

I understand the following with respect to this form:

- I may refuse to complete/sign this form. My refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits.
- If the person(s) receiving information about me through Personal Communication is not a health care provider or a health plan covered by Federal Privacy Regulations, the information may be re-disclosed and no longer protected by Federal Privacy Regulations.
- I may change or revoke this form in writing at anytime, for future Personal Communications.

______________________________________ ______________________
Signature of patient or patient's legal representative — Date

______________________________________ ______________________
Print name of legal representative (if applicable) — Relationship to patient