

2550 West 8th Street, Erie PA 16505 814/833-9533 • Fax 814/833-1621

CONSENT FOR USE AND/OR DISCLOSURE OF HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

	(First)	(Middle Initial)
Date of Birth:		
I understand that any of my personal hac. for purposes of carrying out treatment, recorporation. I have been given the opportunity understand provides a more complete descript understand that it is my right to review the Notice of Privacy Practices Privacy Practices at any time from Erie Audiol	eiving payment, and carryi to review Erie Audiology tion of how my health infor ice of Privacy Practices bet s may change. I understand	ng out other health care operations of , Inc.'s Notice of Privacy Practices, vernation may be used or released. I fore I sign this consent. I also underst
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