CAROLINA HEARING SERVICES, INC.

PATIENT CONSENT/ACKNOWLEDGMENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Carolina Hearing Services, Inc. to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). (Carolina Hearing Services, Inc.'s Notice of Privacy Practice provides a more complete description of such uses and disclosures.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Carolina Hearing Services, Inc. reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Carolina Hearing Services, Inc., Privacy Officer at 1543 Ashley River Road, Charleston, SC 29407.

With this consent, Carolina Hearing Services, Inc., may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any calls pertaining to my clinical care.

With this consent, Carolina Hearing Services, Inc. may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Carolina Hearing Services, Inc. restrict how it uses or discloses my PHI to carry out TPO.

However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to Carolina Hearing Services, Inc.'s use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Carolina Hearing Services, Inc. may decline to provide treatment to me.

______________________________ ______________________

***Signature* of Patient or Legal Guardian** **Date**

____

***Print* Name of Patient or Legal Guardian**