4045 Hempstead Turnpike, Suite 202, Bethpage, NY 11714 – (516) 396-1017
2800 Marcus Avenue, Suite 207, Lake Success, NY 11042 – (516) 622-3387
1100 Franklin Avenue, Suite 300, Garden City, NY 11530 – (516) 248-0068
333 East Shore Road, Suite 102, Manhasset, NY 11030 – (516) 466-0206
3529 Long Beach Road, The Sands Shopping Center, Oceanside, NY 11572 – (516) 442-5322
Southern Boulevard, Suite 4, Nesconset, NY 11767 – (631) 238-5785
1500 Route 112, Bldg 6 – Suite H, Port Jefferson Station, NY 11776 – (631) 928-4599
994 Jericho Turnpike., Suite 203, Smithtown, NY 11787 – (631) 543-1059
5964 Route 25A, Wading River, NY 11792 – (631) 886-2770
510 Montauk Highway, Suite H, West Islip, NY 11795 – (631) 332-3274

As a result of the Health Insurance Portability and Accountability Act (HIPAA), enforced by the US Department of Health and Human Services office of Civil Rights, we are not permitted to release patient information except as stated in the Notice of Privacy Practices, or in accordance with your wishes as stated below.

This waiver authorizes Ear Works Audiology, P.C. to send/give my medical information as noted:

Leave a voice mail recording including my Personal Health Information on my home/cell phone: ☐ YES ☐ NO

Leave a voice mail recording including my Personal Health Information on my business phone: ☐ YES ☐ NO

Use of electronic communications (i.e. email, fax, electronic messaging) to transmit prescription, Treatment, disorder related information, lab or other results: ☐ YES ☐ NO

Permit the individual stated below (Personal Representative) to receive prescriptions and/or test results: ☐ YES ☐ NO

Speak to a family member of my choosing (Personal Representative) regarding my Personal Health Information: ☐ YES ☐ NO

Name of Personal Representative: _____

On this date _____ I received and reviewed Ear Works Audiology, P.C. 's Notice of Privacy Practices, which describes how my medical information may be used and disclosed and explains how I can get access to this information.

I had an opportunity to raise questions regarding this policy and all of my questions have been answered. ☐ YES ☐ NO

The authorizations made above will remain effective until such time as I notify Ear Works Audiology, P.C. in writing, be certified mail, of requested changes.

_____ _____

Patient Signature Date

_____ _____

Patient Phone Number Date of Birth