LAWRENCE
HEARING AID CENTER

**2777 Jefferson Street, Suite 101, Carlsbad, CA 92008**
**Ph: 760-729-8581 Fax: 760-729-8580**

I understand that as part of my healthcare, Lawrence Hearing Aid Center originates and maintains health records describing my health history, symptoms, examinations, and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and treatment information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- And a tool for routine healthcare operations such as quality and reviewing the competence of healthcare professionals

I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that Lawrence Hearing Aid Center is not required to agree to the restrictions requested. I have a right to receive a copy of the authorization upon request.
I understand that I may revoke this consent in writing, except to the extent that Lawrence Hearing Aid Center has already taken action in reliance thereon.
I understand this authorization expires one year from the date this form is signed.
I understand that if my protected health information is disclosed to someone who is not required to comply with the federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected.
I give permission to Lawrence Hearing Aid Center to leave a message on my answering machine and/or voice mail. Therefore, I consent to the use and disclosure of my healthcare information.

☐ I request the following restrictions to the use or disclosure of my health information:

_____

_____ _____

Signature Date