**Lafayette Hearing Center**
**765-448-6226** phone ● **765-448-9416** fax


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# *Release of Information and Consent for Treatment*

□ I give permission to the Lafayette Hearing Center to release information, verbal and written, contained in my medical record and other related information, to my insurance company, rehab nurse, case manager, attorney, employer, related healthcare providers, assignees and/or beneficiaries and all other related persons. Information without patient identifiers may be used for quality purposes.

□ I acknowledge that I have been offered a copy of the Health Insurance Portability and Accountability Act (HIPAA) policy of this office. I am responsible for reviewing this information. This information can be found under the **FORMS** link or under the **PRIVACY** link on our website.

□ I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance of my account and for professional services or purchases rendered.

**I have read and understand all the above information.**

_____________________________________________

Name (a copy of this signature is as valid as the original) Date

Signature of Power of Attorney/Parent/Guardian:

_____________________________________________

Name (a copy of this signature is as valid as the original) Date