CONSENT FOR TREATMENT:
I hereby authorize the personnel of HASA and Hilgenberg Scottish Rite Center to render to the patient whose name appears on this form such care as they deem necessary and appropriate.

AUTHORIZATION TO RELEASE INFORMATION:
I hereby authorize HASA and Hilgenberg Scottish Rite Center to release my diagnosis and other medical information to the third party payer identified to determine benefits payable. Reports will be sent to me electronically or via fax unless otherwise noted. **Please remove The Hearing and Speech Agency from your SPAM folder.**

OUR COMMITMENT TO YOUR PRIVACY:
HASA is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

ASSIGNMENT OF BENEFITS:
I hereby authorize direct payment to HASA of any insurance otherwise payable to me or the patient. I acknowledge the responsibility for any coinsurance, deductible, and/or other sum not received by HASA from any third party source.

ELECTRONIC COMMUNICATION GUIDLELINES & POLICY:
Please be advised that electronic communication is not completely secure and confidential although many measures have been put into place by HASA. Email and other electronic communication are intended for basic information about HASA and for arranging or modifying appointments. Anyone requesting medical records must consider that this is not the safest form of transmission, and must be willing to accept confidentiality risks. Be advised that email is checked during business hours and is not checked on weekends or holidays. We will respond to any requests within two business days of receipt. Client and/or I acknowledge and understand that if an email is sent and I request a response via electronic communication, that the client and /or I are willing to accept the above-stated risks.

PATIENT RIGHTS AND RESPONSIBILITIES:
I have been notified about patient rights and responsibilities including Privacy Practices.

I permit a copy of this authorization to be used in place of the original.

I certify that I understand the contents of this form.

I GIVE CONSENT FOR MY CHILD/FAMILY MEMBER TO RECEIVE THE NECESSARY EVALUATION AND/OR TREATMENT BY HASA.

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Client Name　　　Guardian Name　　　Client/Guardian Signature　　　DATE

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