Abram Audiology
Listen to Life, Clearly.

Dr. Jackie Abram, Audiologist
Owner/Operator
AJ Abram, AB, AA
Office Manager/Hearing Instrument Specialist

HIPAA Authorization & Privacy Acknowledgment Form

Patient Information

Full Name: _____

Date of Birth: _____

Phone Number: _____

Address: _____

I. HIPAA Notice of Privacy Practices Acknowledgment

I acknowledge that I have been provided a copy of Abram Audiology's Notice of Privacy Practices and that I have had the opportunity to ask questions about it. I understand this notice explains:

- How my protected health information (PHI) may be used and disclosed for treatment, payment, and healthcare operations.
- My rights regarding access, amendment, and restriction of my PHI.
- How can I file a complaint if I believe my privacy rights have been violated.

Patient (or Legal Representative) Initials: _____

II. Authorization to Release Medical Information

I authorize Abram Audiology to release or disclose my PHI, including audiological evaluation results, diagnoses, and treatment information, to the following (check all that apply):

☐ Primary Care Physician: _____

☐ ENT/Otolaryngologist: _____

☐ Insurance Provider(s) for claims/payment purposes

☐ Family Member(s):

_____(Name & Relationship)

☐ Other: _____

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This authorization:
- Does not expire unless otherwise specified: _____
- May be revoked in writing at any time, except to the extent that action has already been taken in reliance on this authorization.
- Will not be used for purposes other than those stated above without my written permission, unless required or permitted by law.

III. Communication Preferences

I authorize Abram Audiology to contact me regarding appointments, results, and billing via (check all that apply):

☐ Phone call ☐ Voicemail ☐ Text message ☐ Email

Preferred Contact Method: _____

IV. Patient Rights & Acknowledgments

- I understand I have the right to inspect and obtain a copy of my medical records.
- I understand that HIPAA allows disclosure of PHI without authorization in certain cases (e.g., public health requirements, legal obligations).
- I understand that Abram Audiology will take reasonable safeguards to protect my PHI but cannot guarantee absolute confidentiality of email or text communication.

Signature

Patient or Legal Representative: _____

Relationship to Patient (if applicable): _____

Date: _____

Staff Witness: _____ Date: _____

Clinic Use Only

Date HIPAA Notice Given: _____

Initials of Staff Providing Notice: _____