



# Lawrence Speech & Hearing Services

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## Patient Consent for Use and Disclosure or Protected Health Information

I hereby give my consent for Lawrence Speech and Hearing Services, LLC to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). (Lawrence Speech and Hearing Services, LLC's Notice of Privacy Practices provides a more complete description of such uses and disclosures.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Lawrence Speech and Hearing Services, LLC reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Lawrence Speech and Hearing Services, LLC Privacy Official at 515 Grand Ave, Suite E, Mancos, CO 81328.

With this consent, Lawrence Speech and Hearing Services, LLC may call my home or other alternative location and leave a message on voicemail, or in person, in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care. Lawrence Speech and Hearing Services, LLC may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

I would like to authorize the following listed persons as those whom Lawrence Speech and Hearing Services, LLC may discuss my healthcare and scheduling needs as well as billing issues that may arise **(you are not required to list anyone):**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone \_\_\_\_\_

I have the right to request that Lawrence Speech and Hearing Services restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement until my written authorization is given to end restrictions. By signing this form, I am consenting to Lawrence Speech and Hearing Services, LLC's use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Lawrence Speech and Hearing Services, LLC may decline to provide treatment to me. My signature below also acknowledges my receipt of Lawrence Speech and Hearing Services, LLC's Notice of Privacy Practices.

Patient Signature (or Legal Guardian): \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_