Smith Hearing Healthcare, P.L.L.C.
3400 New Hartford Road, Ste. C
Owensboro, KY 42303
(270) 683-1600

Patient Identification:

Name: ______________________________ Date of Birth:____________________

I acknowledge that Smith Hearing Healthcare has offered me a copy of its Notice of Privacy Practices, which provides a detailed description of the uses and disclosures allowed, as well as other rights I have regarding my Protected Health Information; also Smith Hearing Healthcare has informed me of the "Red Flag" rule and what is required of me in order to be compliant with this legislation.

Communication with Family and Others Involved in My Care

Please list any family members or others who may be involved in coordinating your care or payment for care. Also, indicate what kind of information may be shared with each individual.

Name	**Relationship to Patient**	**Type of Information**			
		All	**Appt.**	**Medical**	**Billing/ Insurance**
______________________	______________	☐	☐	☐	☐
______________________	______________	☐	☐	☐	☐
______________________	______________	☐	☐	☐	☐
______________________	______________	☐	☐	☐	☐

Specific instructions or limitations:____
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We will continue to rely on the information on this form when communicating with family members or others involved in your care unless you request changes. Please promptly notify our office if you wish to alter the designations above.

Signature of Patient:____ Date:______________________

To revoke this authorization, please send a written request to the address below:

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