**SUMMARY OF NOTICE OF HIPAA PRIVACY PRACTICES:**

This notice describes how medical information about you may be used and disclosed and how you can get this information.

We may share your health information to:

Treat you, get paid, tell you about other health benefits and services.

We may use your health information for:

 Health and safety reasons. Workers compensation requests, lawsuits, and law enforcement requests.

We may send you notifications, electronically or by mail.

We may send you educational and or marketing information on the products and services that we offer, with no remuneration involved in these communications.

You have the right to:

 Get a copy of your medical record, change your medical record if you think it is wrong, get a list of when we share your health information with, ask to limit the health information we share, ask for a copy of our privacy notice, complain in writing if you believe your rights have been violated.

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ have reviewed the above and I hereby give consent to use and disclose protected health information to carry out treatment, payment and healthcare operations of Inman Audiology, PLLC. (*Inman Audiology “Notice of privacy Practices* provides a more complete description of such use and disclosures). I understand I may revoke this authorization, in writing, at any time.

With whom, if anyone, may we share your information: *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_