HEARING ASSOCIATES OF SOUTH CAROLINA

SHERRI LITTLE, AU.D
DOCTOR OF AUDIOLOGY

JESSICA MAHAFFEY, AU.D
DOCTOR OF AUDIOLOGY

MIRANDA ROSS, AU.D
DOCTOR OF AUDIOLOGY

HEAR WITH YOU **TOGETHER**

HEARING ASSOCIATES OF SOUTH CAROLINA considers a patient's confidentiality to be of utmost importance and concern. In an effort to ensure that your privacy is protected, please read and sign the following concent form.

PATIENT NAME _____ DATE _____

AUTHORIZATION

I authorize Hearing Associates of SC to leave a message on my home or cell phone messaging system pertaining to the following (check all that apply):

_____ Date and time of upcoming appointments

_____ Hearing Aid related items such as for pick up, warranty expiration, etc.

I authorize Hearing Associates of SC to speak with the following people pertaining to my appointments, finances, and medical treatments. (check all that apply).

_____ Spouse (Name) _____

_____ Son (Name) _____

_____ Daughter (Name) _____

_____ Other (Name) _____

I understand that this authorization will remain in effect until such time that I submit in writing, revocation of my authorization. I understand that by giving my consent to any of the above, information about my healthcare could be made available to members of my family and/or others in my home that have access to my telephone messaging system.

NO AUTHORIZATION

_____ I do not authorize any messages related to any of the above to be left on my home or cell phone messaging system.

_____

Signature Date

39 - A VARDEN DRIVE
AIKEN, SC 29803
(803) 641 - 6104

105 E. HUGH ST., SUITE 103
N. AUGUSTA, SC 29841
(803) 441 - 3937