HEARING CENTER
OF BUCKS COUNTY

AUDIGY CERTIFIED

Brianna Casey, Au.D.
Doctor of Audiology
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Helen Wilson
Audiology Assistant
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Privacy Practices Acknowledgement

I wish to be contacted in the following manner (please check all that apply):

Home Phone: _____

_____ Leave message with detailed information

_____ Leave message with call back number

Cell Phone: _____

_____ Leave message with detailed information

_____ Leave message with call back number

_____ Text message for appointment reminders

Work Phone: _____

_____ Leave message with detailed information

_____ Leave message with call back number

Written Communication:

_____ Mail to home address

_____ Fax to _____

_____ E-mail to _____

I hereby give permission for Hearing Center of Bucks County to disclose information regarding my treatment to:

Spouse: _____

Son/Daughter: _____

Parent(s): _____

Other: _____

Phone Number: _____

Physician: _____

Phone number: _____

In signing this release, I authorize my medical records faxed or mailed upon my request.

Name: _____ **DOB:** _____

(PRINT Patient's Name)

Signature: _____ **Date:** _____

(Signature of patient; if under 18 years of age, signature of parent/guardian)

Upon request, a copy of our Notice of Privacy Practices will be provided for your review.

900 W Trenton Ave
PO Box 46
Morrisville, PA 19067
P: 215.295.7126
F: 215.295.1403

2346 Trenton Rd, Ste E
Levittown, PA 19057
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