Exchange of Information Agreement

I, (client or substitute decision maker's name),_____ hereby give written consent for Heritage Hearing Care and its agents (Audiologists and staff) to provide to the individuals and institutions indicated below and to receive from them information regarding my health information which may include my hearing assessments, hearing aid and assistive device information, information regarding related disorders of the ear or health that pertain to my audiological management, as well as financial information related to my care.

- ☐ My spouse/partner: (full name) _____
- ☐ Specified family members: (full names) _____
- ☐ Health Care Providers in my Circle of Care (my medical doctor, ENT specialist, audiologist, hearing instrument specialist, speech language pathologist or other health care provider related to my audiological care)
- ☐ The supplier/manufacturer of my hearing health care device
- ☐ Teacher for the Hearing Impaired:_____
- ☐ School and School Board: _____
- ☐ Third Party Payers: Veteran's Affairs Canada, WSIB, ODSP, Ontario Works, Assistive Devices Program (ADP), other _____
- ☐ My insurance provider: _____
- ☐ I understand that in the course of business transactions, an accountant, book keeper and financial institutions may see my name linked with HHC's service.

☐ I understand that this information sharing is to better provide service/care for me and that I can revoke this consent at any time verbally or in writing.

☐ I consent for HHC staff to leave a message about my care on my answering machine.

☐ I consent for HHC staff to leave a message with the person answering my home phone.

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"Helping Ears to Hear"