Hearing Specialty Center, LLC

Authorization to Use and Disclosure of Health Information

Patient Name _____ Date _____

Address _____ City/State/ZIP _____

Social Security# _____ Phone# _____

I request and authorize Hearing Specialty Center to disclose my protected health information as described below. I understand that if the person/organization authorized to receive and use the information is not a health plan or health care provider, the disclosed information may no longer be protected by federal privacy regulations.

- I consent to Hearing Specialty Center releasing protected health information as detailed below.
- I prohibit Hearing Specialty Center from using and disclosing medical information to any person or entity other than required by HIPAA regulations.

My protected health information may be used or disclosed to the following:

_____

_____

_____

For the Purpose of:

_____

_____

_____

If you need assistance in completing the authorization form, please contact Cherri Hoyden at choyden@hearingspecialtycenter.com.

I understand that I have the right to request restrictions as to how my protected health information may be used or disclosed by Hearing Specialty Center.

I understand that this authorization is in effect until the revocation section on this form is signed or until written notice of revocation is received. I may revoke this authorization at any time by signing the revocation section of my copy of this form and returning it to Hearing Specialty Center.

I authorize Hearing Specialty Center's use and disclosure of my protected health information as set forth above. I understand that this authorization is voluntary and that Hearing Specialty Center cannot condition my treatment, service, etc. on the signing of this authorization. I understand that if I am signing on behalf of a minor child, this authorization will expire upon the child reaching the age of 18, unless there is proof of legal guardianship.

_____ _____

Printed name of patient or personal representative | Date

_____ _____

Signature of patient or personal representative | Date

EXPIRATION/REVOCATION SECTION

Expiration: This authorization will expire on (must choose one):

- One year from the date it is signed
- Other (insert date or event) _____

Printed name of patient or personal representative	Date
Signature of patient or personal representative	Date

Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice to the address listed at the bottom of this form. I understand that revocation of this authorization will not affect any action that above named entity took in reliance on this authorization before the above named entity received my written notice of revocation.

I hereby revoke this authorization.

Printed name of patient or personal representative	Date
Signature of patient or personal representative	Date