Authorization to Use and Disclosure of Health Information

Patient Name: _____ Date of Birth: _____

I request and authorize Audiology Associates 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.

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

_____

_____

_____

I authorize Audiology Associates use and disclosure of my protected health information as set forth above. I understand that this authorization is voluntary and that Audiology Associates cannot condition my treatment, services, 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

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