AUDIOLOGY ASSOCIATES

hear today, hear tomorrow

Audiology Associates HIPAA Authorization for Use or Disclosure of Health Information

Patient Name: _____ Date of Birth: _____

Address: _____ City: _____

State:_____ Zip Code: _____ Telephone Number: _____

Email: _____ Fax #:_____

This authorizes Audiology Associates to disclose information to:

Recipient Name: _____ Address:_____

City: _____ State: _____ Zip Code:_____

Phone number: _____ Fax number:_____

FOR COPIES, SPECIFY THE HEALTH INFORMATION NEEDED FOR USE OR DISCLOSURE:

☐ Medical Office Records dated from _____ to _____ (Can only request up to previous 7 years)

☐ Mail Records ☐Fax Records

Once this health information is disclosed, how the recipient further discloses it may be no longer protected under federal privacy law (HIPAA).

A copy of this authorization is valid as an original. I have the right to receive a copy of this authorization.

_____ _____

Date Signature of Patient

_____

Printed Name of Patient

**If you are requesting your complete Medical Record there is a $15.00 fee and we have 15 business days to complete. Please make a note above if you would like the records faxed or mailed.

1111 Sonoma Avenue, Suite 316, Santa Rosa, CA 95405, (707) 523-4740 Office (707) 523-0231 Fax