Hearing, Speech & Deafness Center

Artz Communication Center 1625 19th Avenue Seattle, WA 98122 *206.323.5770* www.hsdc.org

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR MARKETING

Patient Name:_____ Date of Birth: _____

Address: _____ City/State/Zip _____

Phone/email: _____

I authorize Hearing, Speech & Deafness Center ("HSDC") to use/disclose my protected health information for marketing related to audiological/health-related products or services. I understand that HSDC or its business associates may receive financial remuneration in exchange for making the marketing communication from or on behalf of the third party whose product or service is being described.

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 Authorize HSDC to use and disclose medical information for any and all marketing purposes and understand that Hearing, Speech & Deafness Center or its business associate may receive financial remuneration in exchange for making the marketing communication for on behalf of the third party whose product or service is being described. A list of anticipated and potential persons/class of persons/organizations to whom information may be disclosed is included below.

☐ I request an Authorization form for each instance HSDC intends to use and disclose medical information for any marketing purposes and understand that HSDC or its business associate may receive financial remuneration in exchange for making the marketing communication or on behalf of the third party whose product or service is being described.

☐ I prohibit HSDC from using and disclosing medical information for any marketing purposes.

A list of anticipated and/or potential persons/class of persons/organizations to whom information may be disclosed:

_____

_____

_____

If you need assistance in completing the authorization form, please call (206) 323-5770.

SIGNATURE Required for Release/Obtain/Exchange of Information- I understand that:

- I have the right to request restrictions as to how my protected health information may be used or disclosed by HSDC.
- This authorization is in effect until the revocation section of this form is signed or until written notice of revocation is received. I may revoke this authorization at any time, except to the extent that action has already been taken based on this authorization, by signing th revocation section of my copy of this form and returning it to HSDC.
- Authorizing the disclosure of this health information is voluntary. My treatment or eligibility will not be conditioned upon my authorization of this disclosure.
- 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.

_____ _____

Signature of Client, Patient or Legal Representative Printed name

_____ _____

Relationship to Client or Patient Date

EXPIRATION/REVOCATION SECTION

This authorization will expire on (must choose one): ☐ One year from the date it is signed ☐ Other (date/event): _____

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

I hereby revoke this authorization.

_____ _____

Signature of Client, Patient or Legal Representative | Printed name

_____ _____

Relationship to Client or Patient | Date