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

I request and authorize Hearing, Speech & Deafness Center to RELEASE/OBTAIN/EXCHANGE healthcare information on:

Name: ________________________________ Birthdate: ________________________

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 prohibit Hearing, Speech & Deafness Center from using and disclosing medical information to any person or entity other than required by HIPAA regulations.

____ I consent to Hearing, Speech & Deafness Center releasing protected health information as detailed below.

MY PROTECTED HEALTH INFORMATION MAY BE USED OR DISCLOSED TO THE FOLLOWING:

Name: ____

Facility: ______________________________________ Phone: ______________________

Address: ______________________________________ Fax: ______________________

Name: ____

Facility: ______________________________________ Phone: ______________________

Address: ______________________________________ Fax: ______________________

FOR THE PURPOSE of Release/Obtain/Exchange of Information:

SPECIFIC INFORMATION to be Released/Obtained/Exchanged:

____ Speech/Language ____ Parent-Infant ____ Educational ____ Psychiatric Reports

____ Audiologic ____ Medical ____ Other ____________________________

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.
- 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

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

____ One year from the date it is signed ____ Other (insert date or 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