

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

To assist Hearing, Speech & Deaf Center in providing the best care possible and to communicate with those close to you and other health professionals that may be treating you, Hearing, Speech & Deaf Center provides you with a form to let us know with whom we can share your health information.

I request and authorize Hearing, Speech & Deaf Center to (circle all that apply) **RELEASE/OBTAIN/EXCHANGE** healthcare information on:

Client Name: _____ DOB: _____

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 & Deaf 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 (circle all that apply) Release/Obtain/ Exchange of Information:
SPECIFIC INFORMATION to be Released/Obtained/ Exchanged:

Speech/Language Parent-Infant Educational Psychiatric Reports
 Audiology Medical Other

SIGNATURE Required for Release/Obtain/Exchange of Information

By signing, 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 the 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 patient or personal representative

Printed name



Hearing, Speech & Deaf Center

Relationship to client or patient

Date

ASSIGNMENT RELEASE

By signing below, I authorize HSDC to release any information require to insurance companies, medical providers, and others as required by law or court order.

Printed name of patient or personal representative

Date

Signature of patient or personal representative

Date

EXPIRATION/REVOCAION 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 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