Authorization to Release or Obtain Health Information

Patient Name: _____ DOB: _____

Address: _____ City: _____ State: _____ Zip: _____

I authorize Advanced Audiology to (place "X" in box):

☐ TO RELEASE Information TO AND/OR ☐ TO OBTAIN Information FROM

Person/Organization Name: _____ Phone: _____

Address: _____ Fax: _____

Specify information to be disclosed:

□ Audiograms □ ENT reports □ MRI/imaging reports □ Other: _____

Purpose of this Authorization:

□ Continuing Care □ Patient request □ Other: _____

Duration of Authorization: The Authorization shall be in effect until my death or the day I revoke permission.

In addition:

I understand I can cancel this authorization at any time, in writing, to Advanced Audiology. Any disclosures made before the authorization was cancelled cannot be taken back.

I understand this authorization is voluntary and not required as a condition of receiving treatment or benefits I am entitled to receive, provided this information is not required to determine if I am eligible to receive those treatment or benefits or to pay for the services I receive.

I understand that information used or disclosed by this authorization may be re-disclosed by the recipient and will no longer be protected by our privacy policies.

I understand that I am entitled to receive a copy of the authorization once signed.

I acknowledge that I have read this form in its entirety and agree to the disclosures above.

X_____ _____

Signature of Patient or Patient's Legal Representative Date Signed

_____

Print Name of Legal Representative and Relationship to Patient (if applicable)