AUDIOLOGY &
Hearing Aid Solutions

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Authorization to Release and Discuss Medical Information

I hereby authorize you to use or disclose the specific information described below, only for the purpose and parties also described below.

Description of the specific information to be released / discussed:

❑ Appointment Date/Times
❑ Audiogram Results
❑ Summary of Medical Records
❑ Diagnosis
❑ Care Plan
❑ Other *(specify)*: _____

Patient Name _____ Date of Birth _____

Information to be given to:

Name _____ Name _____

Relationship _____ Relationship _____

Address _____ Address _____

_____ _____

Phone _____ Phone _____

Fax _____ Fax _____

This authorization shall remain in effect from the date signed below until (please check one):

(Specify expiration date or event) _____/_____/_____ ❑ NO EXPIRATION DATE

I understand that:

- I may inspect or copy the protected health information to be used or disclosed.
- I may revoke this authorization in writing by contacting your office, attention Administrator.
- This authorization is giving Audiology & Hearing Aid Solutions the right to discuss my medical information with the one or more people listed above.
- Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer be protected by the HIPAA
- I may refuse to sign this authorization and you will not condition treatment or payment on my providing this authorization (except to the extent that the authorization is for research-related treatment, in which case you may refuse to provide that research-related information).

Signature: _____ Date: _____

Relationship to Patient *(If signed by personal representative of Patient)*: _____