TAILORED HEARING
AUDIOLOGY & HEARING AID SERVICES

85 E Street, South Portland ME 04106

(P) 207-808-9097

Patient Authorization to Release Protected Health Information (PHI)

Patient Name: _____ DOB:_____

Address: _____ Phone No.:_____

I authorize Tailored Hearing to use or disclose the patient's protected health information (PHI) as described below:

I authorize the use and disclosure of my PHI to be ☐ RELEASED or to be ☐ OBTAINED from the following entity:

Name: _____

Address: _____

Phone: _____ Fax: _____

☐ Records from: _____ to: _____

Records to be released:

☐ Audiological Results
☐ Evaluation / Therapy Results
☐ Reports
☐ Other: _____

For the purpose of:

☐ Patient Request
☐ Continuity of Care
☐ Legal
☐ Other:

If the information includes records or information from another health care provider or entity, that information:

☐ SHOULD be released under this authorization.

☐ SHOULD NOT be released under this Authorization. This Authorization applies only to the information indicated above.

I understand that my medical record contains information to my diagnosis and treatment and authorize the release of all information listed above.

I understand that I may refuse authorization to disclose all or some of the above health information, but refusal may result in improper diagnosis and treatment, denial of coverage or claim for health insurance benefits, or other adverse consequences. Partial or incomplete records will be labeled as such.

I understand I am entitled to a copy of the authorization form, upon request.

This authorization is valid for twelve (12) months from the date signed, and I authorize future disclosure regarding these records the same individual and/ or entities during this period.

I understand that I can revoke all or part of this authorization in writing at any time by delivery of a written, dated and signed notification to the Releaser except to the extent that the Releaser has already acted in reliance on it.

I certify that I have the authority to approve the requested release of information and sign this authorization:

Printed Name:

Patient or Personal Representative Signature: Date: