HIPAA-Authorization to Use and Disclosure of Health Information

Patient Name: _____ Date of Birth: _____

I request and authorize HearCare Audiology Center, Inc. to disclose my protected health information as described below. I understand that if the person/organization authorized to receive and use the information is not a health plan or health care provider, such as hearing aid manufacturers, ear mold companies or buying groups the disclosed information may no longer be protected by federal privacy regulations. I consent to HearCare Audiology Center, Inc. releasing protected health as detailed below.

My protected health information may be used or disclosed to the following:

1. Send appointment reminders to your home/email? Yes ____No ____
2. Leave the following information on your home, cell or work voice mail?

Appointment Information	Yes ____	No____
Billing Information	Yes ____	No ____
Medical Information	Yes ____	No ____

I give my permission to share the following information with the person(s) listed below:

Name: _____ Relationship: _____

Appointment: Yes ____ No ____ Billing: Yes ____ No ____ Medical: Yes ____ No ____

I acknowledge that I received a copy of HearCare Audiology Center, Inc.'s Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, the website and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

This Notice informs me how HearCare Audiology Center, Inc. will use my health information for the purposes of my treatment and/or payment for my treatment. This Notice explains in more detail how HearCare Audiology Center, Inc. may use and share my health information for other than treatment, payment, and health care operations. HearCare Audiology Center, Inc. will also use and share my health information as required/permitted by law.

I understand that I have the right to request restrictions as to how my protected health information may be used or disclosed by HearCare Audiology Center, Inc. I understand that this authorization is in effect until written notice of revocation is received. I may revoke this authorization at any time by providing written notice of revocation to HearCare Audiology Center, Inc., 2800 Hillview Street, Sarasota, FL 34239. 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 authorize HearCare Audiology Center, Inc.'s use and disclosure of my protected health information as set forth above. I understand that this authorization is voluntary and that HearCare Audiology Center, Inc. cannot condition my treatment, services, etc… on the signing of this authorization. I understand that 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.

_____ _____
Printed name of patient or personal representative Date

_____ _____
Signature of patient or personal representative Date

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

☐ This authorization expires on the following date: _____
☐ This authorization expires when the following event occurs: _____

For assistance completing the authorization form contact Eileen Olson at eolson@myhearcare.com.