Audiology Center Northwest

Authorization for Use and/or Disclosure of Health Information/Release of Information

Patient Name: _____ Date of Birth: _____

By signing below, I hereby authorize the use and/or disclosure of individually identifiable health information, which is called "protected health information" (PHI), under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and/or medical, audiologic or hearing aid records relating to me, as described below:

I, _____ do hereby authorize the release of:

- ☐ Audiograms
- ☐ Progress Notes
- ☐ History
- ☐ Operative Reports
- ☐ Lab Reports

Release Information From: _____

Release Information To: _____

The protected health information will be used and/or disclosed for the following purposes:
☐ At the request of the patient listed above
☐ Other _____

- I understand that if the person or entity that receives this information is not a health care provider or health plan covered by HIPAA, the released information may be re-disclosed by the recipient and may no longer be protected by federal or state law.

- I understand that this Authorization for Use and Disclosure expires five years from the date of the authorization listed below. After the expiration date, all additional uses and disclosures would require that a new Authorization for Use and Disclosure be completed.

- I understand that I may revoke this authorization at any time by notifying Audiology Center Northwest in writing. I understand though that if I do so, this revocation will not affect or apply to any actions taken by Audiology Center Northwest before receiving my revocation.

Print Name of Patient: _____

Patient Signature: _____ Date: _____

Patient's Date of Birth: _____

For Patient's Parent or Guardian if applicable:

Print Name of Parent or Guardian: _____

Describe relationship to Patient: _____

Patient Signature: _____ Date: _____

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