HSDC
Hearing, Speech & Deaf Center

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

To assist Hearing, Speech & Deaf Center in providing the best care possible and to communicate with those close to you and other health professionals that may be treating you, Hearing, Speech & Deaf Center provides you with a form to let us know with whom we can share your health information.

I request and authorize Hearing, Speech & Deaf Center to (circle all that apply) RELEASE/OBTAIN/EXCHANGE healthcare information on:

Client Name: ______________________________ DOB: ________________________

I understand that if the person/organization authorized to receive and use the information is not a health plan or health care provider, the disclosed information may no longer be protected by federal privacy regulations.

___ I prohibit Hearing, Speech & Deaf Center from using and disclosing medical information to any person or entity other than required by HIPAA regulations.

___ I consent to Hearing, Speech & Deafness center releasing protected health information as detailed below.

MY PROTECTED HEALTH INFORMATION MAY BE USED OR DISCLOSED TO THE FOLLOWING:

Name:____
Facility: ____ Phone: ____________________________
Address:____ Fax:__________________________________

Name:____
Facility: ____ Phone: ____________________________
Address:____ Fax:__________________________________

FOR THE PURPOSE of (circle all that apply) Release/Obtain/ Exchange of Information:
SPECIFIC INFORMATION to be Released/Obtained/ Exchanged:

___Speech/ Language ___Parent-Infant ___Educational ___Psychiatric Reports
____Audiology ___Medical ___Other

SIGNATURE Required for Release/Obtain/Exchange of Information
By signing, I understand that:

- I have the right to request restrictions as to how my protected health information may be used or disclosed.
- This authorization is in effect until written notice of revocation is received. I may revoke this authorization at any time, except to the extent that action has already been taken based on this authorization.
- Authorizing the disclosure of this health information is voluntary. My treatment or eligibility will not be conditioned upon my authorization of this disclosure.
- 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.

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____ ____
Signature of patient or personal representative Printed name

____ ________________
Relationship to client or patient Date

ASSIGNMENT RELEASE
By signing below, I authorize HSDC to release any information require to insurance companies, medical providers, and others as required by law or court order.

____ ________________
Printed name of patient or personal representative Date

____ ________________
Signature of patient or personal representative Date

EXPIRATION/REVOCATION SECTION

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

___ One year from the date it is signed ___ Other (insert date or event)______________________________

Right to revoke: I understand that I may revoke this authorization at any time by giving written notice to the address listed at the top of this form. 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.

____ ________________
Printed name of patient or personal representative Date

____ ________________
Signature of patient or personal representative Date