HSDC
Hearing, Speech & Deaf Center

Artz Communication Center
1625 19th Ave Seattle, WA 98122
Audiology: 206.323.5770
Speech: 206.388.1300
www.hsdc.org

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I request and authorize Hearing, Speech & Deaf Center to release, obtain, exchange healthcare information on:

Client Name: _____ **DOB:** _____

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

MY PROTECTED HEALTH INFORMATION MAY BE USED OR DISCLOSED TO THE FOLLOWING (e.g., doctor, school, other related service providers):

Name:_____
Facility: _____ Phone: _____
Address:_____ Fax:_____

Name:_____
Facility: _____ Phone: _____
Address:_____ Fax:_____

SPECIFIC INFORMATION to be Released/Obtained/ Exchanged:

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

SIGNATURE By signing, I understand that:

- I have the right to request restrictions as to how my protected health information may be used or disclosed.
- I authorize HSDC to release any information required to insurance companies, medical providers, and others as required by law or court order.
- This authorization is in effect until written notice of revocation to the address listed at the top of this form 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.

_____ _____
Signature of patient or personal representative Printed name

_____ _____
Relationship to client or patient Date