Authorization to Use and Disclosure of Health Information

Patient Name:_____Date of Birth:_____
Address:_____
Social Security #:_____ Phone #:_____

I request and authorize Neuro-Communication Services, Inc dba Hearing Innovations 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, the disclosed information may no longer be protected by federal privacy regulations.

__ I **CONSENT** to Neuro-Communication Services, Inc dba Hearing Innovations releasing protected health as detailed below.

__ I **PROHIBIT** Neuro-Communication Services, Inc dba Hearing Innovations from using and disclosing medical information to any person or entity other than required by HIPAA regulations.

My protected health information may be used or disclosed to the following: (example: John Smith- husband, Jane Doe- daughter)

_____
_____
_____

For the Purpose of:_____
_____

If you need assistance in completing the authorization form, please contact Audra Branham, Au.D. at drbranham@hearinginnovations.com

I understand that I have the right to request restrictions as to how my protected health information may be used or disclosed by Neuro-Communication Services, Inc dba Hearing Innovations.

I understand that this authorization is in effect until the revocation section of this form is signed or until written notice of revocation is received. I may revoke this authorization at any time by signing the revocation section of my copy of this form and returning it to **Neuro-Communication Services, Inc dba Hearing Innovations.**

I authorize Neuro-Communication Services, Inc dba Hearing Innovations use and disclosure of my protected health information as set forth above. I understand that this authorization is voluntary and that Neuro- Communication Services, Inc dba Hearing Innovations 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/REVOCATION SECTION

Expiration: This authorization will expire on (must choose one):
____ One year from the date it is signed
____ Indefinitely

_____

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

I hereby revoke this authorization.

_____ _____
Printed name of patient or personal representative Date

_____ _____
Signature of patient or personal representative Date