Elk Grove HEARING CARE

HIPAA Authorization for Release of Protected Health Information

Patient Name _____ D.O.B. _____

I HEREBY AUTHORIZE the release/disclosure of my protected health information as described below:

1. The following individual or organization is authorized to make the release:

   Elk Grove Hearing Care
   9300 W Stockton Blvd., Ste 103
   Elk Grove, CA 95758

2. The type and amount of information to be disclosed is as follows:

   ☐ Audiology Records Only ☐ Complete Medical Records

3. I understand that the information in my chart may include information of a sensitive nature including information related to behavioral or mental health.

4. This information may be released to and used by the following organization:

   _____
   Physician, Medical Group or Organization Name

   _____
   Street Address

   _____
   City/State/Zip

   _____
   Phone Fax

5. I understand that I can revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and send my written revocation to Elk Grove Hearing Care. I understand that the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire in twelve months or on the following date, event or condition:

   _____

I understand that authorizing the disclosure of protected health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to receive benefits. I understand that I may inspect or copy information to be used or disclosed. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by privacy rules. If I have any questions about disclosure of my health information, I can contact:

Elk Grove Hearing Care
9300 W Stockton Blvd., Ste 103
Elk Grove, CA 95758
Phone: (916) 627-1494
Fax: (916) 897-8853

_____ _____
Signature of Patient, Parent, or Legal Guardian Date