© Advanced Hearing Center

17390 Preston Road, Suite 320 • Dallas, Texas 75252

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the use or disclosure of my individually identifiable health information as described below, which may include information concerning communicable diseases such as Human Immunodeficiency Virus ("HIV") and Acquired Immune Deficiency Syndrome ("AIDS"), mental illness (except for psychotherapy notes), chemical or alcohol dependency laboratory test results, medical history, treatment, or any other such related information. I further understand that my health care and the payment of my health care will not be affected if I do not sign this form.

I understand that if the recipient authorized to receive this information is not a covered entity, e.g. insurance company or non-health care provider, the released information may no longer be protected by federal and state privacy regulations. This form must be completely filled out.

Patient Name: _____ SS#: _____

Phone Number: _____ DOB: _____

Dates of Service (if known) _____

Description of information to be released: (Check all that apply)

- ☐ Audiological Testing
- ☐ Hearing Aid Information (settings)
- ☐ History and Physical
- ☐ Labs
- ☐ Progress Notes
- ☐ Radiology Films
- ☐ Operative Reports
- ☐ Consultation Reports
- ☐ Discharge Summary
- ☐ Radiology Report
- ☐ Nurse's Notes
- ☐ Physician Orders
- ☐ Entire Chart

Description of the purpose of the use and/or disclosure: _____

_____

The health information described herein shall be released to (check the appropriate category)

☐ Hospital ☐ Physician ☐ Insurance Company ☐ Attorney ☐ Patient ☐ Other _____

Medical Provider to release records:

_____

_____

_____

_____

Persons/organizations receiving the information:

_____

_____

_____

_____

I understand that this authorization will expire by law 180 days from the date of this authorization unless I otherwise specify. I desire this authorization to be in effect until _____ (Expiration date/event).

I further understand that I may revoke this authorization at any time by notifying the providing organization in writing and if I do, it will not have any affect on any actions they took before they received the revocation.

I understand that I may see and copy the information described on this form if I ask for it, and that I get a copy of this form after I sign it. Further I understand there may be a fee for a copy of this information.

_____ _____

Signature of Patient or Patient's Guardian/Representative Date

_____ _____

Printed Name of Patient's Guardian/Representative Relationship to Patient

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