Authorization for the Use or Disclosure of Health Information

Patient Information

Name:____ Date of Birth _________________
Address: ____ Phone: ______________________
City: _______________________________ State: __________ Zip code: _____________________

By signing below, I hereby authorize my health information, as described below to be used or disclosed by Elkhart Audiology Rehab. (This information is referred to as "Protected Health Information").

I hereby authorize: Elkhart Audiology Rehab, 663 County Rd. 17 Suite 1, Elkhart, IN 46516– Phone 574-262-3277 or Fax 866-528-1982.

To _____Release and disclose my Protected Health Information to:
To _____ Receive my Personal Health Information from:

Name: ____
Address: ____
City: ____State _____________ Zip code: ____________

This authorization shall remain in effect for one year from the date of the signature. This authorization will expire on: _______________________. I understand I have the right to revoke this Authorization in writing.

Information To Be Released

_____Most Recent Audiogram
_____ All Test Results (Audio, tymp etc.)
_____ Case History Information
_____ Progress Notes
_____Hearing Instrument Model and Serial Number
_____ Hearing Instrument Repair Warranty Info.
_____ Physician Report/ Letter
_____ Other: ____________________________

Reason for Disclosure

_____ Personal
_____Continuing Patient Care
_____ Insurance
_____ Attorney
_____ Other: _______________________________________

Delivery Method:_____ Mail _____ Fax _____Verbal _____Patient/ Representative Pick UP

Notice to Recipient of Elkhart Audiology Rehab Information: This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulations prohibit you from making any further disclosure of it without specific written content of the person to whom it pertains.

Signature of Patient: ____ Date: __________
Signature of Legal Representative: ______________________________________ Date: ___________
Printed Name: ____