AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

This authorization permits Advanced Audiology to disclose your health information including information about medical treatment, audiogram, and medical reports. Please review it carefully.

Patient Name _____

I authorize Advanced Audiology to disclose my health information to:

_____

(Name)

The records to be disclosed are: _____ All Records _____ Doctors Notes

Re-disclosure: Information that Advanced Audiology uses or discloses based on the authorization I am giving may be subject to re-disclosure by the person who receives the information and may no longer be protected by the federal privacy rules.

Right to Revoke: I also understand that I may revoke this authorization at any time by delivering a written revocation to Advanced Audiology at 1113 College Ave. Suite C145 Manhattan, KS 66502.

Refusal: I have the right to refuse to give Advanced Audiology this authorization. If I do not give the authorization, it will not affect the treatment I receive or the methods used to obtain reimbursement for my care, except, however, if my treatment at Advanced Audiology is for the sole purpose of creating health information for disclosure to the recipient identified in this Authorization, in which case, Advanced Audiology may refuse to treat me if I do not sign this authorization.

Inspect/Copy: I may inspect or copy the information that Advanced Audiology may send at any time.

Term: This notice is in effect until written revoke is initiated.

Authorization to file Medicare and Insurance

I hereby authorize my insurance carrier to release payment directly to Advanced Audiology. I understand that Advanced Audiology is a Medicare, Blue Cross/Blue Shield Provider and will not balance bill you for the services beyond their maximum allowable amount.

Acknowledgement of Notice of Privacy Practices

By signing below, I acknowledge that I have received a copy of Advanced Audiology Notice of Privacy Practices. I have read about the use and disclosure of my health information, and other concerns regarding my health information.

_____

Signature of Patient

Date: _____

_____

Signature of Personal Representative (if applicable)