Authorization to Use and Disclosure of Health Information

Patient Name: ______________________________

I request and authorize Wake Audiology & Hearing Aid Associates 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.

My protected health information may be used or disclosed to the following for the purpose of:

Picking up hearing aids and/or supplies, assisting in care, scheduling appointments, and general information.

Spouse______________________________ Friend(s) ______________________________

Child/Children ____

Physician ______________________________ Other ________________________________

Yes / No (circle one) - May we remind you of your appointments and/or leave a detailed message on your: home, cell, work voice mail or e-mail address?

Yes / No (circle one) - Would you like a report sent to your primary care physician?

EXPIRATION: This authorization will expire on:
(must choose one):

☐ One year from the date it is signed ***Or*** ☐ As long as I am a patient here

____ ______________________________
Signature of patient or personal representative Date

Continued on Back

If you need assistance in completing the authorization form, please contact Ginny Lillie, at (919) 570-8311 or ginny@wakeaudiology.com.

I understand that I have the right to request restrictions as to how my protected health information may be used or disclosed by Wake Audiology & Hearing Aid Associates.

I authorize Wake Audiology & Hearing Aid Associates' use and disclosure of my protected Health information as set forth above. I understand that this authorization is voluntary and that Wake Audiology & Hearing Aid Associates 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.

Two to three times a year we email or mail patients information regarding medical updates for hearing loss and product updates. Please let us know if you do not want to be included in these notices.

Right to Revoke: I understand that this authorization is in effect until I give written notice of revocation to Wake Audiology & Hearing Aid Associates, 1954 South Main Street, Wake Forest, NC 27587. 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.

To Be Completed by Staff

Staff member sought but was unable to obtain an acknowledgment from the patient or the patient's personal representative for the following reason:

☐ Patient/personal representative refused to sign form

☐ Other ____

____ _______________________________

Signature of staff member Date