FLORESVILLE
830.542.8957
FAX: 830.542.8958
1605 US HWY 181 N.
Suite A
Floresville, TX 78114

DOSS AUDIOLOGY
& HEARING CENTER

SCHERTZ
210.819.5002
FAX: 210.819.5003
645 Woodland Oaks Dr.
Suite 350
Schertz, TX 78154

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

PATIENT INFORMATION

First Name: _____ M.I.: _____ Last Name: _____

Address:_____City:_____Zip:_____

Home/Cell Phone: (_____) _____-_____ Work Phone: (_____) _____-_____

Date of Birth: ____/____/_____ Social Security #: _____

I authorize the custodian of records of : _____ to disclose/ release the following information: (Select all applicable)

All Records: ☐

Cochlear Implant Records: ☐

Cochlear Implant Programming Files: ☐

Audiology Records: ☐

Other: _____ ☐

PLEASE SEND RECORDS ABOVE TO:

DOSS AUDIOLOGY & HEARING CENTER
645 Woodland Oaks Drive, STE 350
Schertz, TX 78154
PHONE: 210-819-5002
FAX: 210-819-5003
EMAIL: INFO@DOSSAUDIOLOGY.COM

I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment, receive payment, or eligibility for benefits unless allowed by law. By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pedning or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information. This authorization expires one year from the date of signature.

Patient/Parent/Guardian Name: _____

Patient/Parent/Guardian Signature: _____ **Date:** ___/___/_____