Family Hearing Center
18 Westage Business Center Drive, Fishkill NY 12524
Tel: 845-897-3059; Fax: 845-897-3254

Authorization to Use & Disclosure of Health Information

Name: _____ DOB: _____

I request and authorize Family Hearing Center 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 a Health Care Provider, the disclosed information may no longer be protected by federal privacy regulations.

I consent to Family Hearing Center releasing my Protected Health Information as detailed below. (If you want to allow someone in your Family to have access to your Medical Records, list their name(s) below)

_____

For the Purpose of: _____

I prohibit Family Hearing Center from using and disclosing my medical information to any person or entity other than required by HIPAA regulations. (For you only, write SELF ONLY)

_____

I understand that I have the right to request restrictions as to how my Protected Health Information may be used or disclosed by Family Hearing Center.

I understand that this authorization is in effect until the revocation section of this form is signed or until written notice of revocation is received. I may revoke this authorization at any time by signing the revocation section of my copy of this form and returning it to Family Hearing Center.

I authorize Family Hearing Center's use and disclosure of my Protected Health Information as set forth above. I understand that this authorization is voluntary and that Family Hearing Center 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.

X_____ Date:_____

Signature of Patient/Guardian or Personal Representative

EXPIRATION / REVOCATION SECTION:

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

One year from the date it is signed

Other (insert date or event):_____

Right To Revoke: I understand that I may revoke this authorization at any time by giving written notice to the address listed at the bottom of this form. 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.

I hereby revoke this authorization:

X_____ Date:_____

Signature of Patient/Guardian or Personal Representative