

HIPAA Authorization for Release of Protected Health Information

Patient Name _____ Date of Birth _____

I HEREBY AUTHORIZE the release/disclosure of my protected health information as described below:

1.) Pee Dee Hearing Center is authorized to make the release

2.) The type and amount of information to be disclosed is as follows:

Audiology Records Only Complete Medical Records

3.) I understand that the information in my chart may include information of a sensitive nature including information related to behavioral or mental health.

4.) This information may be released to and used by the following organization:

Physician, Medical Group or Organization Name

Street Address

City/State/Zip

Phone

Fax

5.) *I understand that I can revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and send my written revocation to **Pee Dee Hearing Center**. I understand that the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire in twelve months or on the following date, event or condition:*

I understand that authorizing the disclosure of protected health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to receive benefits. I understand that I may inspect or copy information to be used or disclosed. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by privacy rules. If I have any questions about disclosure of my health information, I can contact:

153 E N.B. Baroody St, Florence, SC
(843) 662.7802153

Signature of Patient, Parent, or Legal Guardian

Date

