JACKSON COUNTY AUDIOLOGY
CHARLES E. HARE, M.S., CCC/A • ROBERTA M. BEILE, M.A., CCC/A

816.373.7900

Authorization to Use and Disclosure of Health Information

Patient Name:_____ **Date of Birth:** _____

I request and authorize Jackson County Audiology 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.*

1. Please choose one of the options below:

__ I consent to Jackson County Audiology releasing protected health as detailed below.
__ I prohibit Jackson County Audiology from using and disclosing medical information to any person or entity other than required by HIPAA regulations.

2. If you chose "I consent" above, then complete the following: **My protected health information may be used or disclosed to the following** (we must know WHO we can speak with if you chose "consent" above. For example, spouse, daughter, son, caregiver, etc.):

Name	Relationship to you	Phone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____

3. If there are limitations as to what we can speak with the above named person/people about, please list here. (Examples: "only drop off/pick up hearing aids" or "just to buy batteries" or "just to make appointments", etc.). If not specified, we will assume we may speak with them about anything.

_____
_____

I authorize Jackson County Audiology's use and disclosure of my protected health information as set forth above. I understand that this authorization is voluntary and that Jackson County Audiology cannot condition my treatment, services, etc… on the signing of this authorization (meaning you are not required to sign to be treated).

Printed name of patient (or personal representative as necessary) Date

_____ _____

Signature of patient (or personal representative as necessary) Date

_____ _____

If this form is being signed on behalf of a minor child, I understand that this authorization will expire upon the child reaching the age of 18, unless there is proof of legal guardianship.

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EXPIRATION/REVOCATION SECTION

Expiration: This authorization (to speak to the person/people named above) will expire on (must choose one):

__ One year from the date it is signed
__ Future date (insert date): _____
__ Until Revoked by me in writing
__ Upon death

If you need assistance in completing the authorization form, please contact Tawna Noftzger, at (816) 373-7900 or info@JacksonCountyAudiology.com.

I understand that I have the right to request restrictions as to how my protected health information may be used or disclosed by Jackson County Audiology.

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 **Jackson County Audiology.**

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.

STOP

DO NOT SIGN UNLESS YOU ARE REVOKING THE ABOVE AUTHORIZATION!

I hereby revoke this authorization.

Printed name of patient (or personal representative as necessary) Date

_____ _____

Signature of patient (or personal representative as necessary) Date

_____ _____