Authorization to Use and Disclosure of Health Information

Patient Name: ________________________________ Date of Birth: ___________________

I request and authorize Francis Audiology LLC. 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.

☐ I consent to Francis Audiology LLC to release protected health information as detailed below.

☐ I prohibit Francis Audiology LLC from using and disclosing medical information to any person or entity other than required by HIPAA regulations.

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

PATIENT PROVIDES AUTHORIZED PARTIES, NAME, ADDRESS, CONTACT INFO

____

____

For the Purpose of:

EXAMPLE: PICK UP HEARING AIDS and/or ASSIST IN CARE

____

If you need assistance in completing the authorization form, please contact Carol Langer 724-933-3440 or email clanger@francisaudiology.com.

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

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 Francis Audiology LLC.

Authorization to Use and Disclosure of Health Information

I authorize Francis Audiology LLC's use and disclosure of my protected health information as set forth above. I understand that this authorization is voluntary and that Francis Audiology LLC 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.

_______________________________________   __________________

Printed name of patient or personal representative

_______________________________________   __________________

Signature of patient or personal representative   Date

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):____

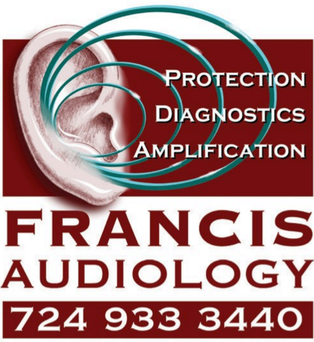
Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice to the address listed at the bottom of this form. I understand that revocation of this authorization will not affect any action the above named entity took in reliance on this authorization before the above named entity received my written notice of revocation.

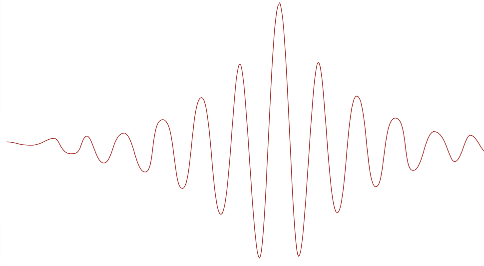
I hereby revoke this authorization.

--__________________
Printed name of patient or personal representative

________________________________   __________________

Signature of patient or personal representative   Date





Building Hearing Solutions
For Over 25 Years!

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

□ By checking this box and signing below, I acknowledge that I received a copy of Francis Audiology Associates' Notice of Privacy Practices. The Notice provides information about how we may use and disclose the medical information that we maintain about you. We encourage you to read the full Notice. I understand that a copy of the current Notice will be posted in the reception area, the website (if applicable) and that any revised Notice of Privacy Practices will be made available.

____

Printed name of patient or personal representative

____ ____________________

Signature of patient or personal representative Date

Authorization and Release for the Use and/or Disclosure of Protected Health Information for Marketing

Patient Name: ______________________________ Date of Birth: ____________________

I authorize Francis Audiology Associates to use/disclose my protected health information for marketing related to audiological/health-related products or services. I understand that Francis Audiology Associates or its business associates may receive financial remuneration in exchange for making the marketing communication from or on behalf of the third party whose product or service is being described.

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.

· I Authorize Francis Audiology Associates to use and disclose medical information for any and all marketing purposes and understand that Francis Audiology Associates or its business associate may receive financial remuneration in exchange for making the marketing communication for on behalf of the third party whose product or service is being described. A list of anticipated and potential persons/class of persons/organizations to whom information may be disclosed is included below.

· I request an Authorization form for each instance Francis Audiology Associates intends to use and disclose medical information for any marketing purposes and understand that Francis Audiology Associates or its business associate may receive financial remuneration in exchange for making the marketing communication or on behalf of the third party whose product or service is being described.

· I prohibit Francis Audiology Associates from using and disclosing medical information for any marketing purposes.

A list of anticipated and/or potential persons/class of persons/organizations to whom information may be disclosed:

Offers from Francis Audiology
Hearing Instrument Manufacturers,
Assistive Device Manufacturers

If you need assistance in completing the authorization form, please contact Carol Langer at clanger@francisaudiology.com.

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

I understand that this authorization is in effect for the term set forth below or until the revocation section of this form is signed and received. I may revoke this authorization at any time by signing the revocation section of my copy of this form and returning it to **Francis Audiology Associates.**

Authorization and Release for the Use and/or Disclosure of Protected Health

Information for Marketing

I authorize Francis Audiology Associates' use and disclosure of my protected health information as set forth above. I understand that this authorization is voluntary and that Francis Audiology 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.

____

Printed name of patient or personal representative

____ ___________________

Signature of patient or personal representative Date

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.

____

Printed name of patient or personal representative

____ ___________________

Signature of patient or personal representative Date