AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

Patient Name: ____ Date of Birth:______________________

I request and authorize Bloomington-Normal Audiology to disclose/receive 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 Bloomington-Normal Audiology releasing/obtaining protected health as detailed below.
- I prohibit Bloomington-Normal Audiology 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:

____

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For the purpose of:

____

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If you need assistance in completing the authorization form, please contact Natalie McKee, Au.D. at 309-662-8346 or contactus@bnaudiology.com.

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

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

____ __________________________

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 Date

____ ________________________

Signature of Patient or Personal Representative Date