bloomington normal audiology
Hear for you.

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Release of Information to a Designated Party

We are required by law to protect your information in your health record. This includes any information about you and your test results, hearing aids, appointments, billing and health insurance. The following information will allow us to discuss these items, in part or in whole, with people that you designate.

Do you have a Power of Attorney? _____ Yes _____ No
If yes, please provide the person's name and documentation: _____

Name or Organization	Relationship	Test Results	Billing	Insurance	Hearing Aid Care	Appts

Please list any additional persons that may also be included and your preferences:

I authorize Bloomington-Normal Audiology (BNA) to use and disclose my information as described in this authorization. Please read and agree to the following statements:

- I understand this information will expire only when revoked in writing by the patient.
- I understand that I may revoke this authorization at any time by notifying the office in writing. However, if I do revoke this authorization, it will not have any effect on any actions taken by BNA prior to the receipt of the revocation.
- I understand that this authorization is voluntary.
- I understand that once this information is released to the Designated Party (ies), the released information may no longer be protected by Federal privacy regulations.
- I understand that my treatment cannot be conditioned on whether I sign this authorization.

_____ _____ _____
Printed Name Signature Date