Lutherville
1447 York Road
Suite #312
Lutherville, MD 21093
410-583-7021

Bel Air
2103 Laurel Bush Road
Suite A
Bel Air, MD 21015
410-569-8884

Perry Hall
8615 Ridgelys Choice Drive
Suite #103
Nottingham, MD 21236
410-238-2353

Virginia
493 Blackwell Road
Suite #311
Warrenton, VA 20186
540-341-7112

www.hearingassessment.com
Fax: 410-583-2117

Patient Authorization for Use and Disclosure of Protected Health Information

I, _____ authorize the Hearing Assessment Center to use and/or disclose certain protected health information (PHI) about me to:

Name, phone number, and address of Doctor or other entity to receive this information:

This authorization permits Hearing Assessment Center to use and/or disclose Audiological Test Findings about me. The information will be disclosed for the furtherance of care or at the request of the individual. This form is provided so I can make an informed decision whether to allow release of the information. **This authorization will expire in 12 months from the date of signing.**

The practice will not receive payment or other remuneration from a third party in exchange for using or disclosing the PHI.

I do not have to sign this authorization in order to receive treatment from the Hearing Assessment Center, LLC. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subjected to redisclosure by the recipient and may no longer be protected by the Federal HIPPA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Official at:

Hearing Assessment Center, LLC; 1447 York Road, Suite 312; Lutherville, MD 21093

Print Patient Name:

_____ _____

Signature of Patient or Legal Guardian | Date

_____ _____

Print Name of Legal Guardian (if applicable) | Relationship to patient (if applicable)