Privacy Disclosures

Patient's Name: _____ Date of Birth: _____

Phone Number: _____

Our policy at Family Audiology Associates, Inc., is not to disclose any of your private healthcare information to your family members, friends, or loved ones. We will not be able to release any information about your healthcare without your written consent. This includes information to parents, boyfriends, girlfriends, friends, husbands, wives, or other relatives. **Do not include physicians on this form.** If you wish to have your private healthcare or treatment information released to another individual you must read and complete the following:

First and Last Names of Authorized Person(s):

1.) Name: _____ Phone Number: _____

Relationship: _____

2.) Name: _____ Phone Number: _____

Relationship: _____

3.) Name: _____ Phone Number: _____

Relationship: _____

I authorize the above named healthcare provider to release the information specified to the organization/agency/individual named on this request. Method of release shall be pertinent to the need and may include photocopies, fax copies, personal review, audio, video, electronic, or verbal communication to appropriate individual. I understand that with this authorization, all information contained in my chart/file may be released including test results, alcohol/drug abuse information, psychological/psychiatric information unless otherwise indicated.

I understand that if the person or entity that received the information is not a healthcare provider or health plan covered by privacy regulations, the information described above may be disclosed and is no longer protected by those regulations.

I understand that this authorization will remain valid indefinitely unless otherwise revoked by me in writing. I also understand that I may revoke this authorization in writing at any time by notifying the Privacy Officer, except to the extent that action has already been taken in reliance on this authorization.

_____ _____

Signature of Patient or Guardian Date