Sierra Hearing Center

Improve your hearing. Improve your life.

HIPAA Authorization to Disclose Protected Health Information

Patient Name _____ D.O.B. _____

I HEREBY AUTHORIZE the disclosure of my protected health information as described below:

1. The following individual or organization is authorized to make the disclosure:

_____
Physician, Medical Group or Organization Name

_____
Street Address

_____
City/State/Zip

_____
Phone Fax

2. The type and amount of information to be disclosed is as follows:

☐ Speech Therapy Records Only ☐ Speech Therapy and Audiology Records

☐ Audiology Records Only ☐ Complete Medical Records

3. I understand that the information in my chart may include information of a sensitive nature including information related to behavioral or mental health.

4. This information may be disclosed to and used by the following organization:

Sierra Hearing Center
900 Ryland Street
Reno, NV 89502

5. I understand that I can revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and send my written revocation to Sierra Hearing Center. I understand that the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire in twelve months or on the following date, event or condition:

_____

I understand that authorizing the disclosure of protected health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to receive benefits. I understand that I may inspect or copy information to be used or disclosed. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by privacy rules. If I have any questions about disclosure of my health information, I can contact:

Sierra Hearing Center
900 Ryland Street
Reno, NV 89502
(775) 329-7017

_____ _____
Signature of Patient, Parent or Legal Guardian Date