Authorization and Release for the Use and/or Disclosure of Protected Health Information

Patient Name:____
Patient Address:____
Patient Telephone Number:____
Patient Date of Birth:____

I authorize Audiology Specialists, LLC and Encore Hearing, LLC to use/disclose my protected health information for the purpose of providing me with educational information, reminders about appropriate services and professional care and for the purpose of helping me improve my hearing.

Audiology Specialists and Encore Hearing will **NOT** release your protected health information in exchange for financial remuneration (we will not sell your information).

The Government defines marketing *as any form of contact that may encourage you to make an appointment, pay for service or purchase a product.* It is possible that any contact we initiate with you would have one of these outcomes. This is why it is necessary to ask for authorization to allow marketing communications.

If we share your information with your insurance company, or any other company which may provide a product you request, you need to know that these companies are not considered a health plan or health care provider. Therefore, the information disclosed to them may not be protected by Federal Privacy Regulations.

Please select one of the following:

_______ I authorize Audiology Specialists and Encore Hearing to use/disclose my protected health information for the purpose of providing me with educational information, reminders about appropriate services and professional care and for the purpose of helping me improve my hearing with hearing aids or other assistive hearing products.

______ I prohibit Audiology Specialists or Encore Hearing from using and disclosing my medical information for any marketing purpose (please see explanation above). Making this selection inhibits our ability to send reminders or useful information.

If you need assistance in completing this authorization form, please speak to our staff or contact Laura O. Robertson, Au.D. at 603 528-7700 or e-mail us at info@audiologyspecialists.com.

My authorization of the use of my protected health information is voluntary. I have the right to request restrictions as to how my protected health information may be used or disclosed by Audiology Specialists or Encore Hearing. I also understand that this authorization is in effect until the Revocation Section of this form is signed and received by Audiology Specialists or Encore Hearing. If I am signing for a minor child, this authorization will expire upon the child's 18th birthday, unless there is proof of legal guardianship.

I authorize my protected health information to be released to: (Please list spouse and/or other family member, friend, etc. and give their relationship to you. Please include their telephone number as well.

____
____
____
____

______________________________________ ________________________
Signature of Patient Date