Hearing Consultants

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I, _____, hereby authorize _____
(NAME OF PATIENT) (NAME OF PERSON OR FACILITY WHICH HAS INFORMATION)

to release the following health information: _____

_____

to: _____
(NAME AND TITLE OR FACILITY NAME TO RECEIVE HEALTH INFORMATION)

_____
(STREET ADDRESS) (CITY, STATE) (ZIP CODE)

_____ _____
(PHONE NUMBER) (FAX NUMBER)

For the following purposes: _____

This authorization if in effect until: _____, when it will expire.
(DATE OR EVENT)

I understand that by signing this authorization:

- I authorize the use or disclosure of my individually identifiable health information as described above for the purpose listed.
- I have the right to withdraw permission of the release of my information. If I sign this authorization to use or disclose information, I can revoke that authorization at any time. The revocation must be made in writing and will not affect information that has already been used or disclosed.
- I have the right to receive a copy of this authorization.
- I am signing this authorization voluntarily and treatment, payment, or my eligibility for benefits will not be affected if I do not sign this authorization.
- I further understand that a person to whom records and information are disclosed pursuant to this authorization may not further use or disclose the medical information unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

_____ _____
(SIGNATURE OF PATIENT OR LEGAL GUARDIAN) (DATE)
Minor's signature is required for release of any records for treatment which the minor may authorize under Colorado Law.

Relationship (if other than patient): _____ ☐ Power of Attorney ☐ Death Certificate

Name of individual signing on behalf of patient: _____

Verification: ☐ Driver's license # _____ ☐ Or other appropriate ID: _____

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