Chester Heights
Hearing Aid Center, LLC

Hearing Healthcare Professional Authorization for the Use and Disclosure of Individually Identifiable Health Information

BY SIGNING THIS FORM, I UNDERSTAND THAT I AM GIVING CHESTER HEIGHTS HEARING AID CENTER, LLC THE AUTHORIZATION TO USE OR DISCLOSE THE FOLLOWING INFORMATION:

Specify Information to be Used/Disclosed:

_____

_____

Specify the Purpose for Which Information will be Used/Disclosed:

_____

_____

RECIPIENT: My health information described above may be disclosed by the practice to the following person(s) or class of persons:

RIGHT TO REVOKE: I understand that I may revoke my authorization at any time by notifying the Practice in writing, mailed to the office listed below. I also understand that my revocation will not be valid if the practice has already taken action in reliance on this authorization or if this authorization is obtained as a condition for obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.

RE-DISCLOSURE: I understand that the information I authorize a person or entity to receive may be re disclosed and no longer protected by the federal privacy regulations.

REFUSAL: I have the right to refuse to give the Practice this authorization. If I do not give the authorization, it will not affect the treatment I receive or the methods used to obtain reimbursement for my care, except, however if my treatment is for the sole purpose of creating health information for disclosure to the recipient identified in this authorization, the Practice may refuse to treat me if I do not sign this authorization.

Inspect/Copy: I may inspect or copy the information that the Practice may send at any time.

TERM: This authorization is effective as of the date set forth below and will remain in effect until the following date or event: _____

CONTACT: I may contact the Practice's privacy officer by mail at: *327 W. Baltimore Pike, Floor #1, Chester Heights, Pa. 19063 or by telephone at 484-574-8777*

I hereby acknowledge that I have received a copy of this authorization. I have read and understand the terms of this authorization and I have had an opportunity to ask question about the use and disclosure of my health information. By my signature, I hereby knowingly and voluntarily authorize the Practice to use or disclose my health information in the manner described above:

_____ _____

Signature of Patient or Personal Representative **Effective Date**

_____ _____

Print Patient Name **Description of Personal Rep's Authority** *(if applicable)*

_____

Print name of Personal Representative *(if applicable)*

327 W. Baltimore Pike
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