AUTHORIZATION USE AND DISCLOSE HEALTH INFORMATION
Center for Better Hearing, LLC
160 West Street, Bldg 1, Cromwell, CT 06416

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1. I give my authorization to use or disclose my protected health information as described in section 2 below.

Name _____

Legal Responsibility

- If you are 18 years old or older, you are legally responsible for yourself.
- If you are an emancipated child or teenager and your parents no longer have custody over you.
- If you are a child or teenager and your parents are divorced (please complete info below of who has custody of you.

The Use and or Disclosure

A. I understand that under the HIPPA regulations, my health information will be used and disclosed to my health care provider who is involved with my medical treatment or services, my health insurance plan, and any medical billing clearinghouse who is involved with your insurance claims fulfillment.
B. Under these new regulations the following people must be authorized by you to have access to your health information: your spouse, family members, friends, nursing facility, legal guardian or other organization who is not involved with your medical treatment, insurance plan or payment.

Below please list the people/organizations that you authorize to have access to your information with this office:

Name _____ Contact Phone _____

Relationship to Patient _____

Date disclosure will expire _____

Name _____ Contact Phone _____

Relationship to Patient _____

Date disclosure will expire _____

2. CHANGING YOUR MIND ABOUT THE AUTHORIZATION

I understand that I may revoke this authorization at any time by giving written notice to the Privacy Manager.

A. METHOD OF CONTACT

Center for Better Hearing, LLC will use the following methods to contact you when necessary.

( ) Home Phone ( ) Work Phone ( ) OK to leave message with details

( ) OK to send mail to home address ( ) OK to send e-mail if applicable

B. STATEMENT OF UNDERSTANDING

I have reviewed and I understand this Authorization. I also understand that my health information will be used or disclosed to certain business associates of Center for Better Hearing, LLC who are part of the health care process. These business associates will also keep your health information confidential.

Patient _____ **Date** _____

Authorized person other than Patient _____ Date _____

Relation to Patient _____