HEARING DOCTORS OF HAWAI`I , LLC

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I authorize Hearing Doctors of Hawaii, LLC to release the protected health information of:

Patient Name: _____ Birthdate: _____
Address: _____
Phone: _____

Release to: _____
Method of Delivery:
☐ Mail to: _____
☐ *Fax to: _____
☐ *Email to: _____
*I understand that there is some level of risk that information sent by fax or unsecured email can be intercepted, forwarded, printed, or read by a third party. By signing this form, you agree to accept the risk of delivery by unsecured means.

Information to be disclosed:	**Purpose of Use and/or Disclosure:**
Date(s) of Service: _____	☐ **Legal Purposes**
☐ **Entire Record**	☐ **Insurance**
☐ **Audiogram**	☐ **Continuing Healthcare**
☐ **Other (please specify): _____**	☐ **Other: _____**

This authorization if in effect for one year or 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.
- Any facsimile, copy or photocopy of the authorization shall authorize you to release the records requested herein. This authorization shall be in force and effect until two years from date of execution at which time this authorization expires.
- Reasonable fees may apply to certain requests

_____ _____
(SIGNATURE OF PATIENT OR LEGAL GUARDIAN) (DATE)

If signed by someone other than the patient or parent of a minor child, please indicate relationship and provide documents to show authority to authorize release of patient's protected health information.
Relationship (if other than patient): _____ ☐ Power of Attorney ☐ Other_____

Name of individual signing on behalf of patient: _____

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