



AUDIOLOGY & Hearing Aid Solutions

www.audioandhearing.com

1115 Clifton Avenue, Suite 102, **CLIFTON**, NJ 07013 • **973-777-5335**
1 Cedar Crest Village, **POMPTON PLAINS**, NJ 07444 • **973-831-5677**
6 Forest Avenue, Suite 100, **PARAMUS**, NJ 07652 • **201-368-1130**
1069 Ringwood Avenue, Suite 301, **HASKELL**, NJ 07420 • **973-777-5335**
21 Franklin Turnpike, Suite 11, **MAHWAH**, NJ 07430 • **201-368-1130**
131 Madison Avenue, 2nd Floor, **MORRISTOWN**, NJ 07960 • **973-777-5335**

Authorization to Release and Discuss Medical Information

I hereby authorize you to use or disclose the specific information described below, only for the purpose and parties also described below.

Description of the specific information to be released / discussed:

- Appointment Date/Times
- Audiogram Results
- Summary of Medical Records
- Diagnosis
- Care Plan
- Other (specify): _____

Patient Name _____ Date of Birth _____

Information to be given to:

Name _____ Name _____

Relationship _____ Relationship _____

Address _____ Address _____

Phone _____ Phone _____

Fax _____ Fax _____

This authorization shall remain in effect from the date signed below until (please check one):

(Specify expiration date or event) ____/____/____

NO EXPIRATION DATE

I understand that:

- I may inspect or copy the protected health information to be used or disclosed.
- I may revoke this authorization in writing by contacting your office, attention Administrator.
- This authorization is giving Audiology & Hearing Aid Solutions the right to discuss my medical information with the one or more people listed above.
- Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer be protected by the HIPAA
- I may refuse to sign this authorization and you will not condition treatment or payment on my providing this authorization (except to the extent that the authorization is for research-related treatment, in which case you may refuse to provide that research-related information).

Signature: _____ Date: _____

Relationship to Patient (If signed by personal representative of Patient): _____