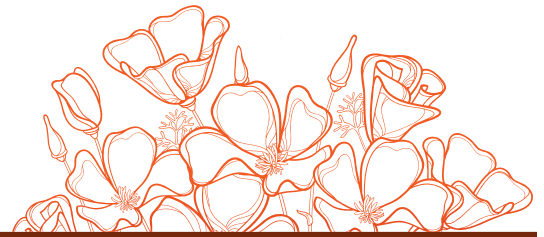


# AUDIOLOGY ASSOCIATES

— OF REDDING —



## HIPAA Authorization to Disclose Protected Health Information

Patient Name \_\_\_\_\_ D.O.B. \_\_\_\_\_

I HEREBY AUTHORIZE the disclosure of my protected health information as described below:

1. This information may be released to and used by the following organization:

\_\_\_\_\_  
Physician, Medical Group or Organization Name

\_\_\_\_\_  
Street

\_\_\_\_\_  
City/State/Zip

\_\_\_\_\_  
Phone; Fax

2. The type and amount of information to be disclosed are as follows:

Audiology Records Only  Complete Medical Records

3. I understand that the information in my chart may include information of a sensitive nature, including information related to behavioral or mental health.

4. This information may be disclosed to and used by the following organization:

*Audiology Associates of Redding*  
*3328 Churn Creek Road, Suite A*  
*Redding, CA 96002*

5. I understand that I can revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and send my written revocation to Audiology Associates of Redding. I understand that the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire in 12 months or on the following date, event or condition: \_\_\_\_\_

I understand that authorizing the disclosure of protected health information is voluntary. I can refuse to sign this authorization. I need not sign this form to receive benefits. I understand that I may inspect or copy information to be used or disclosed. I understand that any disclosure of information carries with it the potential for unauthorized redisclosure and that privacy rules may not protect the information. If I have any questions about the disclosure of my health information, I can contact:

**Audiology Associates of Redding**  
**3328 Churn Creek Road, Suite A**  
**Redding, CA 96002**

\_\_\_\_\_  
Signature of Patient, Parent or Legal Guardian

\_\_\_\_\_  
Date