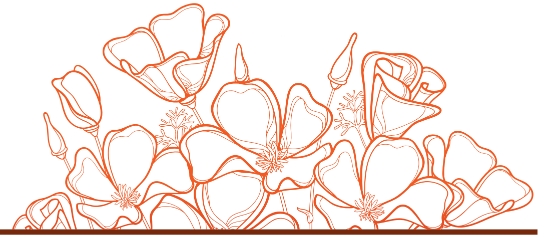
AUDIOLOGY
ASSOCIATES
— OF REDDING —



HIPAA Authorization for Release of Protected Health Information

Patient Name ____ D.O.B. ____________

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

1. **The following individual or organization is authorized to make the release:**
   Audiology Associates of Redding
   3328 Churn Creek Road, Suite A
   Redding, CA 96002

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 released to and used by the following organization:

   ____
   Physician, Medical Group or Organization Name

   ____
   Street

   ____
   City/State/Zip

   ____
   Phone; Fax

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.

   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