Northwest Florida ENT

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Authorization for Use and/or Disclosure of Health Information/Release of Information

Patient Name: Robert L. Smith

By signing below, I hereby authorize the use and/or disclosure of individually identifiable health information, which is called "protected health information" or "PHI" under the Health Insurance Portability and Accountability Act of 1996 or "HIPAA", and/or medical, audiologic or hearing aid records relating to me, as described below:

Specific Description of the Information to be Used and/or Disclosed Including:

Date(s) of Service: _____

Persons Authorized to Make the Use and/or Disclosure: Northwestern University Audiology Clinic

Persons to Whom the Use or Disclosure May be Made:

- ○ **Physician(s)**
  Name and address of physician: _____
- ○ **Other:** _____
  _____
  _____

The protected health information will be used and/or disclosed for the following purposes:

- ○ At the request of the patient listed above
- ○ Other: _____

- I understand that if the person or entity that receives this information is not a health care provider or health plan covered by HIPAA, the released information may be re-disclosed by the recipient and may no longer be protected by federal or state law.

- I understand that this Authorization for Use and Disclosure expires five years from the date of the authorization listed below. After the expiration date, all additional uses and disclosures would require that a new Authorization for Use and Disclosure be completed.

- I understand that I may revoke this authorization, at any time, by notifying Northwestern University Audiology Clinic in writing. I understand though that if I do so, this revocation will not affect or apply to any actions taken by Northwestern University Audiology Clinic before receiving my revocation.

Print Name of Patient: _____

Signature of Patient: _____

Date: _____

Patient's Date of Birth: _____

For Patient's Parent or Guardian, if applicable:

Print Name of Parent or Guardian: _____

Describe relationship to Patient: _____

Signature of Parent or Guardian: _____

Date: _____