Nilsson Audiology &
Hearing Aid Clinic LLC
Hearing Care From The Heart **Joy Nilsson, Au. D.**

Authorization to Use and Disclosure of Health Information

Patient Name:_____ Date of Birth:_____

I request and authorize Nilsson Audiology & Hearing Aid Clinic, LLC to disclose my protected health information as described below. I understand that if the person/organization authorized to receive and use the information is not a health plan or health care provider, the disclosed information may no longer be protected by federal privacy regulations.

○ **I consent to Nilsson Audiology & Hearing Aid Clinic, LLC releasing protected health as detailed below.**

○ **I prohibit Nilsson Audiology & Hearing Aid Clinic, LLC from using and disclosing medical information to any person or entity other than required by HIPAA regulations.**

My protected health information may be used or disclosed to the following: _____
_____
_____
_____

For the Purpose of: HEARING HEALTH

I understand that I have the right to request restrictions as to how my protected health information may be used or disclosed by Nilsson Audiology & Hearing Aid Clinic, LLC.

I understand that this authorization is in effect until the revocation section of this form is signed or until written notice of revocation is received. I may revoke this authorization at any time by signing the revocation section of my copy of this form and returning it to Nilsson Audiology & Hearing Aid Clinic, LLC.

I authorize Nilsson Audiology & Hearing Aid Clinic, LLC's use and disclosure of my protected health information as set forth above. I understand that this authorization is voluntary and that Nilsson Audiology & Hearing Aid Clinic, LLC cannot condition my treatment, services, etc… on the signing of this authorization. I understand that if I am signing on behalf of a minor child, this authorization will expire upon the child reaching the age of 18, unless there is proof of legal guardianship.

Expiration: This authorization will expire on (must choose one):

○ One year from the date it is signed ○ Indefinitely ○ Other Date_____

You have the right to revoke the above authorization at any time. Right to Revoke forms are available upon request. _____

_____ _____
Printed name of patient or personal representative Date

_____ _____
Signature of patient or personal representative Date