AUTHORIZATION FOR USE / DISCLOSURE OF PROTECTED HEALTH INFORMATION

ChEARS Inc. 3590 Camino Del Rio North, San Diego, CA 92108
Phone: (619) 810-1204 Fax: (619) 517-3233

As required by HIPAA and California law, this practice may not use or disclose your individually identifiable health information except as provided in our Notice Of Privacy Practices without your authorization. **Your completion of this form means that you are giving permission for the uses and disclosure described below.**

I hereby authorize *ChEARS Hearing Center* *3590 Camino Del Rio N., Suite 201, San Diego, 92108*
To disclose health information concerning: Fax # or Address

_____ _____ _____
Patient Name Date of Birth Phone Number

_____
Address

This health information may be disclosed to:

_____ _____ _____
Name of person to receive the health information Phone Number Fax Number

_____
Address

Specify Records: ☐ Medical Information _____ (initials)

☐ Hearing Tests & Reports _____ (initials)

The information may be used only for the following purposes:

☐ At the request of the patient

☐ Other _____

Duration: This authorization shall become effective immediately and shall remain in effect for one year from the date of signature unless a different date is specified here _____ (date)
Revocation: This authorization is also subject to written revocation by the patient at any time. The written revocation will be effective upon receipt, except to the extent that the disclosing party or others have acted in reliance upon this authorization.
Re disclosure: I understand that the recipient may not lawfully further use of disclose the health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

I understand that I have the right to receive a copy of this authorization. A copy of this authorization is as valid as the original.

_____ _____ _____
Signature If signed by other than patient, indicate relationship Date