Your Hearing Now, Inc
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Your Hearing Now, Inc – HIPAA Privacy Authorization Form

(Authorization for Use and/or Disclosure of Protected Health Information as Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

Your Hearing Now, Inc is required by law to maintain the privacy of your protected health information. Unless you notify Your Hearing Now, Inc that you object, we may provide your health information to those involved in the provision, support, and delivery of your audiological hearing health care. This may include but is not limited to your family, friends, hearing instrument manufacturers, insurance providers, licensed and qualified hearing health and medical personnel, and for public health purposes including disease reporting.

1. I authorize Your Hearing Now, Inc to use and disclose my protected health information for the purposes of my audiological healthcare.

2. This authorization for the release of information covers the period of healthcare from (choose one):
   ❑ All past, present, and future periods **OR** ❑ _____ to _____
   Date Date

3. ❑ I authorize the release of my complete audiological history
   OR
   ❑ Other (specify): _____
   _____

4. This authorization shall remain in force and effect until further notice or until _____ (date) at which time this authorization expires.

5. I understand that I have the right to revoke this authorization in writing at any time. I understand that a revocation is not effective to the extent that any person or entity that has already acted in reliance and authorization was obtained as a condition of the authorization prior to revocation.

6. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer by protected by state or federal law.

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Printed Name of Patient or Personal Representative Relationship to Patient