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Authorization to Use and/or Disclose Protected Health Information

I authorize the following person/persons to use and/or disclose my health information as identified below:

Name and relationship to patient:____

Name and relationship to patient:____

Name and relationship to patient:____

Name and relationship to patient:____

Name and relationship to patient:____

By signing below, I authorize the disclosure on all the following information, unless otherwise specified:

- All chart notes and reports
- Billing statements and records
- Audiometric studies
- Phone/email/mail/in-person correspondence
- Other____

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I understand that I may revoke this authorization at any time by giving written notice to Aurora Audiology LLC. Unless revoked, this authorization will be in effect as of the date of signing.

Patient's PRINTED Name:________________________________ DOB: ____/____/____

Patient's (or Authorized) Signature:________________________ Date: ____/____/____