Authorization and Release for the Use and/or Disclosure of Protected Health Information for Marketing

Patient Name: _____ Date of Birth: _____

Address: _____ City/State/Zip _____

Social Security #: _____ Phone #: _____

I authorize Family Hearing Services to use/disclose my protected health information for marketing related to audiological/health-related products or services. I understand that Family Hearing Services or its business associates may receive financial remuneration in exchange for making the marketing communication from or on behalf of the third party whose product or service is being described.

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 Authorize Family Hearing Services to use and disclose medical information for any and all marketing purposes and understand that Family Hearing Services or its business associate may receive financial remuneration in exchange for making the marketing communication for on behalf of the third party whose product or service is being described. A list of anticipated and potential persons/class of persons/organizations to whom information may be disclosed is included below.

☐ I request an Authorization form for each instance Family Hearing Services intends to use and disclose medical information for any marketing purposes and understand that Family Hearing Services or its business associate may receive financial remuneration in exchange for making the marketing communication or on behalf of the third party whose product or service is being described.

☐ I prohibit Family Hearing Services from using and disclosing medical information for any marketing purposes.

A list of anticipated and/or potential persons/class of persons/organizations to whom information may be disclosed:
Hearing aid manufacturers, Buying groups.

If you need assistance in completing the authorization form, please contact Kelli Burnett at kelli@familyhearingservices.com.

I understand that I have the right to request restrictions as to how my protected health information may be used or disclosed by Family Hearing Services.

I understand that this authorization is in effect for the term set forth below or until the revocation section of this form is signed and received. I may revoke this authorization at any time by signing the revocation section of my copy of this form and returning it to **Family Hearing Services.**

I authorize Family Hearing Services' use and disclosure of my protected health information as set forth above. I understand that this authorization is voluntary and that Family Hearing Services 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.

_____ _____

Printed name of patient or personal representative Date

_____ _____

Signature of patient or personal representative Date

EXPIRATION/REVOCATION SECTION

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

☐ One year from the date it is signed

☐ Other (insert date or event):_____

Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice to the address listed at the bottom of this form. I understand that revocation of this authorization will not affect any action the above named entity took in reliance on this authorization before the above named entity received my written notice of revocation.

I hereby revoke this authorization.

_____ _____

Printed name of patient or personal representative Date

_____ _____

Signature of patient or personal representative Date