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Associates, P.C.
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Hoover Hearing Clinic
A division of
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HIPAA Authorization for Use or Disclosure of Protected Health Information

The HIPAA privacy rule gives individuals the right to request a restriction of uses and disclosures of their protected health information (PHI). This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

I wish to be contacted in the following manner (Please check all that apply and provide the phone number(s) or email below):

Home# _____ Work# _____

Cell# _____ Email _____

Okay to leave message with detailed information Home Work Cell Email

Leave message with call back number only Home Work Cell Email

My protected health information may be released to the following individuals:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

I understand that this consent remains in effect until I revoke it in writing. I have the right to discontinue services at any time. I further understand that I have the right to change the above information at any time by completing another form.

 Printed Name of Patient

 Date of Birth

 Patient or Legal Representative Signature

 Date Signed