2913 Corporate Circle, Suite 300, Flower Mound, TX 75028
Phone 817-997-4084
Fax 817-333-1190
www.flowermoundfamilyhearing.com

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

I understand that as part of my healthcare, Family Hearing Practice originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care and treatment. I understand that this information is utilized to plan my care and treatment, to bill for services provided to me, to communicate with our healthcare providers and other routine healthcare operations such as assessing quality and reviewing competence of healthcare professionals.

The Family Hearing Practice *Notice of Privacy Practices* provides specific information and complete description of how my personal health information may be used and disclosed. I have been provided a copy of or access to the *Notice of Privacy Practices* and understand that I have the right to review the notice prior to signing this consent. I understand that Family Hearing Practice has the right to change the *Notice of Privacy Practices.* Prior to implementation of the revised *Notice of Privacy Practices,* the revised *Notice* will be mailed to me if information for treatment, payment, or healthcare operations and that Family Hearing Practice is not required to agree to the restrictions requested. I may revoke this consent at any time in writing except to the extent that Family Hearing Practice has taken action in reliance on my prior consent. This consent is valid until revoked by me in writing.

I request the following restrictions on the use and/or disclosure of my protected health information:

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I further understand that any and all records, whether written, oral, or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.

I give permission for my protected health information to be disclosed for purposes of communicating results, finding, and care decisions to:

Name: ______________________________ Name: ______________________________

Name: ______________________________ Name: ______________________________

(Please make sure if the patient is a minor that you have included any family members you would like for us to share information with.)

I have been provided and reviewed the Family Hearing Practice *Notice of Privacy Practices.* I understand that if I have any questions or complaints, I may contact the practice's HIPAA Compliance Officer at 817-997-4084.

Printed Name: ______________________________

Signature: ______________________________ **Date:** ______________________________

If not patient, relationship to patient: ______________________________

If you are the patient's Power of Attorney, please provide us with documentation for our records.