HIPPA Release of Information
AUTHORIZATION FORM

I, ______________________, hereby authorize **The Hearing Center of Chestertown**, its affiliates, employees and agents, to release my personal health information relating to the diagnosis, treatment and health care services provided regarding my auditory health. The information may include my name, address, birth date or other data to identify me to the entity to which the information is released. These entities being:

Name	*Relationship to Patient*

This authorization is valid from the date of my/my representative's signature below and shall expire the earlier of ________________________ or the date my relationship with **The Hearing Center of Chestertown** ends.

I understand I have the right to revoke this authorization by providing written notice to **The Hearing Center of Chestertown**. However, this authorization may not be revoked if **The Hearing Center of Chestertown**, its employees or agents have taken action on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization.

I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility to receive care, but will hinder The Hearing Center of Chestertown's ability to collect payment for services from my insurance company. In such a case, I will pay the full price for services when received.

Signature ____ Date: ____________________

If applicable, Legal Representatives sign below: *By signing this form, I represent that I am the legal representative of the patient identified above and will provide written proof (e.g. Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the patient's behalf with respect to this authorization form.*

Name of Legal Representative ____

Signature of Legal Representative ____ Date: ______________

Name of Witness: ____

Signature of Witness: ____