Protected Health information release

Please list all person(s) that you wish to have access to your audiological information (i.e.: spouse, sibling, children, friend etc), including test results, payment information, and repair pick-ups. Doctors, other healthcare facilities, disability/ social security, Vocational Rehab representatives, and V.A. representatives are not necessary to list. **You may leave this portion of the form blank if you choose, please be advised that if left blank we will NOT release any information or hearing aids to anyone other than the patient or legal guardian of the patient.**

1)_____ 3)_____

2)_____ 4)_____

☐ I give Permission for my PCP, ENT, or any other Health facilities to release information related to my Hearing care to FIRST COAST HEARING CLINIC, including but not limited to – Patient identifiers, hearing tests, health reports, medication lists and other heath related information for treatment and review of my hearing health and I may revoke this release at any time in writing.

Please mark ONE box.

☐ I Give permission for First Coast Hearing to leave a detailed voice message regarding my personal audiological information i.e.: repairs, appointments, test results etc. including patient identifiers.

☐ I DO NOT give permission First Coast Hearing to leave a detailed voice message regarding my personal audiological information i.e.: repairs, appointments, test results etc.

First Coast Hearing uses an auto confirmation system. How would you prefer to receive your confirmations? If you select e-mail or text please make sure you have provided us with the appropriate information. You may choose more than one.

☐ VOICE ☐ TEXT

☐ E-MAIL _____

I understand that this form will be valid unless otherwise canceled in writing by the patient or legal guardian.

Name (Printed)_____

Signature_____ Date_____