Authorization for the Use or Disclosure of Protected Health Information

GARY D. SCHWARTZBERG, Au.D.
Doctor of Audiology

As required by the Health Insurance Portability and Accountability Act of 1996 *Gary D. Schwartzberg, Au.D.* may not use or disclose your health information except as provided in our Notice of Privacy Practices without your authorization. Your signature on this form indicates that you are giving permission for the uses and disclosures of protected health information described herein. You may revoke this authorization at any time by signing and dating the revocation section on your copy of this form and returning to this office.

AUTHORIZATION SECTION

I, _____ (print name) hereby authorize the <use / disclosure / use and disclosure> of the following health information that pertains to me or my dependant

AUDIOLOGICAL EVALUATIONS

for the following purpose<s>:

1) FOR MEDICAL/SURGICAL MANAGEMENT
2) FOR THE PURPOSES OF OBTAINING AMPLIFICATION

I authorize the following persons to make these disclosures of my health information:

GARY D. SCHWARTZBERG, AuD, FAAA

I authorize the following persons to receive these disclosures of my health information:

1)
2)
3)
4)

I understand that information disclosed pursuant to this authorization may be re-disclosed to additional parties and no longer protected.

I understand that I may revoke this authorization at any time by signing the revocation section of my copy of this form and returning it to **Gary D. Schwartzberg, Au.D.** I further understand that any such a revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this authorization.

I understand that this authorization is in effect until the revocation section of this form is signed or until written notice of revocation is received.

I understand that I am under no obligation to sign this authorization. I further understand that <my ability to obtain treatment, my eligibility for benefits, etc.> will not depend in any way on whether I sign this authorization or not.

I understand that I have a right to inspect and to obtain a copy of any information disclosed pursuant to this authorization.

I understand that **Gary D. Schwartzberg, Au.D.** may receive compensation for the uses and disclosures that I have authorized.

_____ _____

Signature Date

REVOCATION SECTION

I hereby revoke this authorization.

_____ _____

Signature Date