

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name: _____

Date of Birth: ____/____/____

Address: _____

Social Security #: _____

Phone #: _____

I request and authorize Kentucky Audiology & Tinnitus Services (“KATS”) to disclose my protected health information in the manner described below. I understand that information disclosed pursuant to this authorization may be redisclosed by the recipient and in such case will no longer be protected by federal privacy regulations.

I understand that KATS does **not** need my authorization for uses and disclosures of my protected health information for the purpose of treatment, payment, and health care operations.

- I consent to Kentucky Audiology & Tinnitus Services releasing protected health as detailed below.
- I prohibit Kentucky Audiology & Tinnitus Services from using and disclosing medical information to any person or entity other than required by HIPAA regulations.

My protected health information may be used or disclosed in the following detailed manner:

To the following person(s) and/or entities (include full address)	Information to be disclosed (for example: “She may have full access to all of my records,” or “they may have access only to...”)	For this specific purpose (e.g. “For insurance purposes,” or “at my request”)

If you need assistance in completing this form, please contact Ann L. Rhoten at
arhoten@kysinstitutetreatment.com.

I understand that I have the right to request restrictions as to how my protected health information may be used or disclosed by KATS.

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 may revoke this authorization at any time, however I understand that revocation of this authorization will not affect any action KATS has already taken in reliance on this authorization before it received my written notice of revocation.

Revocation of this authorization can be achieved by signing the revocation section of my copy of this form and returning it to:

Kentucky Audiology & Tinnitus Services
1517 Nicholasville Road #202
Lexington, KY 40503

I authorize KATS's use and disclosure of my protected health information as set forth above. I understand that this authorization is voluntary and that KATS cannot condition my treatment, procedures, or other services on the signing of this authorization. I understand that if I am signing on behalf of a minor child, this authorization will expire upon the child reaching the age of 18, unless there is proof of legal guardianship.

Printed name of patient or personal representative

____/____/_____
Date

Signature of patient or personal representative

____/____/_____
Date

Personal representatives: In the space below, please describe your authority to act on behalf of the patient.

FILL OUT TODAY'S DATE ON THE FIRST SECTION OF THE NEXT PAGE.

EXPIRATION/REVOCAION SECTION

Date of signature on Authorization to Use and Disclosure of Health Information: ____/____/_____

Expiration: This authorization will expire on (must choose one):

- One year from the date it is signed (which will be ____/____/_____)
- Other date: ____/____/_____
- When the following event occurs: _____

Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice to:

Kentucky Audiology & Tinnitus Services
1517 Nicholasville Road #202
Lexington, KY 40503

I understand that revocation of this authorization will not affect any action Kentucky Audiology & Tinnitus Services has already taken in reliance on this authorization before the above named entity received my written notice of revocation.

I hereby revoke this authorization.

Printed name of patient or personal representative

____/____/_____
Date

Signature of patient or personal representative

____/____/_____
Date

Personal representatives: In the space below, please describe your authority to act on behalf of the patient.
