HIPAA Authorization for Release of Protected Health Information

Patient Name ____ D.O.B. ____________________

I HEREBY AUTHORIZE the release/disclosure of my protected health information as described below:

1. The following individual or organization is authorized to make the release:

   University of the Pacific
   Department of Audiology
   155 Fifth Street
   San Francisco, CA 94103

2. The type and amount of information to be disclosed is as follows:

   ☐ Audiology Records Only ☐ Complete Medical Records

3. I understand that the information in my chart may include information of a sensitive nature including information related to behavioral or mental health.

4. This information may be released to and used by the following organization:

   ____
   Physician, Medical Group or Organization Name

   ____
   Street Address

   ____
   City/State/Zip

   ____
   Phone Fax

5. I understand that I can revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and send my written revocation to the University of the Pacific Hearing & Balance Center. I understand that the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire in twelve months or on the following date, event or condition:

   ____

I understand that authorizing the disclosure of protected health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to receive benefits. I understand that I may inspect or copy information to be used or disclosed. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by privacy rules. If I have any questions about disclosure of my health information, I can contact:

University of the Pacific
Department of Audiology
155 Fifth Street
San Francisco, CA 94103
Phone: (415) 780-2001

____ ____________________
Signature of Patient, Parent, or Legal Guardian Date