Release of Confidential Information

I hereby authorize **West Valley Hearing Center** to disclose protected health information, including but not limited to, dates of service, test results and recommendations.

Name:____ Date of Birth:__________________
First Middle (if applicable) Last Month/date/year

To: ______________________________________

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- I understand that this information will be kept confidential and will be utilized by professional personnel for the sole purpose of diagnosis and treatment.
- This authorization shall be in force and effect for one year, unless otherwise specified.
- I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to West Valley Hearing Center. I understand that a revocation is not effective to the extent that West Valley Hearing Center has relied on the use or disclosure of the protected health information.
- I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and many no longer be protected by federal or state law.
- West Valley Hearing Center will not condition my treatment on whether I provide authorization for the requested disclosure.

I understand I have the right to:

1. Inspect or copy the protected health information to be used or disclosed as permitted under federal law
2. Refuse to sign this authorization.

_____________________________________ ______________________________
Signature of Patient (or representative) **Date**

If not signed by patient, please indicate relationship to patient:

- Parent or Guardian of Minor Child
- Guardian or Conservator of an Incompetent Patient
- Beneficiary or Personal Representative of Deceased Patient
- Other:____________________________________