635 Mid-Florida Dr, Suite 2
Lakeland, FL 33813
O: 863-646-3277
F: 863-646-3299
AspireHearing.com

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

PATIENT INFORMATION:

First Name: _____ M.I.: _____ Last Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: ___/___/_____ Cell Phone: (____) _____-_____ Home Phone: (____) _____-_____

AUTHORIZATION FROM:

I authorize, _____, to disclose/release the following information:

- ☐ All records
- ☐ All Audiology Related Records
- ☐ Clinic/Chart/Progress Notes and/or Reports
- ☐ Cochlear Implant Programming Files
- ☐ Cochlear Implant Records
- ☐ Other: _____

AUTHORIZATION TO:

☐ ASPIRE HEARING & BALANCE
635 Mid-Florida Drive, Suite 2
Lakeland, FL 33813
PHONE: 863-646-3277
FAX: 863-646-3299
EMAIL: INFO@ASPIREHEARING.COM

☐ _____
_____
_____
_____
_____
_____

PURPOSE:

☐ Treatment/Continued Care ☐ Personal ☐ Legal ☐ Insurance ☐ Disability ☐ Other: _____

I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment, receive payment, or eligibility for benefits unless allowed by law. By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.
This authorization will expire (check one): ☐ Until I revoke this authorization ☐ One-year from date signed

Print Name of Patient/Parent/Legal Guardian: _____

Signature of Patient/Parent/Legal Guardian: _____ **Date**: ___/___/_____