Authorization to Use and/or Disclose Protected Health Information

Aurora audiology

I authorize the following person/persons to use and/or disclose my health information as identified below:

Name: _____ Relationship to patient: _____

Contact phone number: _____ Emergency Contact: ❑

Name: _____ Relationship to patient: _____

Contact phone number: _____

Name: _____ Relationship to patient: _____

Contact phone number: _____

Name: _____ Relationship to patient: _____

Contact phone number: _____

I understand that I have the right to revoke this consent, in writing, at any time, except to the extent that Aurora Audiology has taken action in reliance on this consent. Unless revoked, this authorization will be in effect as of the date of signing.

Patient Name: _____ DOB: _____

Patient's Signature: _____ Date: _____

Parent or Legal Guardian or POA: _____ Date: _____