Rankin Clinical Audiology
4600 Hale Parkway Suite 450
Denver, CO 80220
303-698-7378

HIPAA Privacy Authorization Form RE: Release of Records to Rankin Clinical Audiology

Effective Date: _____

Authorization for Use or Disclosure of Protected Health Information (Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

1. **Authorization**. I authorize _____ to use and disclose the protected health information described below to ***Rankin Clinical Audiology***.
2. **Effective Period**. This authorization for release of information covers all past, present, and future periods of health care.
3. **Extent of Authorization**. I authorize the release of my complete health record with the exception of the following information: Mental health records, communicable diseases (including HIV and AIDS), alcohol/drug abuse treatment.
4. **Use.** This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposed as I may direct.
5. **Termination**. This authorization shall be in force and effect until _____, at which this authorization form expires.
6. **Revocation Rights.** I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition obtained insurance coverage and the insurer has a legal right to contest the claim.
7. **Benefits.** I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditions on whether I sign this authorization.
8. **Disclosure.** I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Patient/Guardian Signature: _____ **Date:** _____

Printed Name: _____