Audiology associates
Better Hearing Begins Now!

25425 Orchard Village Rd.
Suite #220
Santa Clarita, CA 91355

Patient Authorization of Disclosure

In general, the HIPAA Privacy Rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home. The patient may revoke or change this authorization at any time with a written request.

I wish to be contacted in the following manner (Check all that apply):

Home Telephone:

- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only
- ☐ Work Telephone
- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only
- ☐ Do not call me at work

Written Communication:

- ☐ O.K. to mail to my home address
- ☐ O.K. to fax to my home fax:
- ☐ OTHER: _____

Patient Signature: _____ Date: _____

In a further effort to protect your health information and the confidentiality of your healthcare, we ask that you designate below to whom the staff at **AUDIOLOGY ASSOCIATES** may discuss your healthcare and scheduling needs as well as billing issues that may arise.

- ☐ Only disclose information to myself

Name_____ Relationship_____ Phone_____
Name_____ Relationship_____ Phone_____

Patient Signature: _____ Date: _____