Stephanie Long, AuD., Inc. About Better Care Audiology
W 3124 Van Roy Road Appleton, WI 54915 (920) 915-9077

AUTHORIZATION FOR USE AND DISCLOSURE OF INFORMATION

Name of Patient:_____ Parent Name:_____

Date of Birth:_____ Age:_____ Phone #:_____
I authorize About Better Care Audiology to Release and Exchange Information to/from:

Name:_____ Name:_____
Address:_____ Address:_____
_____ _____

Name:_____ Name:_____
Address:_____ Address:_____
_____ _____

SPECIFIC DESCRIPTION OF INFORMATION TO BE USED AND DISCLOSED

(specify dates for each, unless "entire medical record" is selected)
Stephanie Long, Inc. About Better Care Audiology treatment from _____(date) to _____(date)

_____ Audiology _____ Other _____

__ Verbal discussion only—do not release any written records.

PURPOSE OF THE USE AND DISCLOSURE

_____ Further Treatment (Date of Appointment_____)
_____ Insurance Application _____Personal Records
_____ Disability Determination _____Education
_____ Vocational Rehabilitation Evaluation _____Payment of Insurance Claims
_____ At my request _____Legal
_____ Other _____

I authorize the use and disclosure of my individually identifiable health information as described above, including verbal and written exchanges about the information unless I indicated otherwise.
I understand that this authorization is voluntary. I understand that if the person or organization I authorize to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and could be re-disclosed. I understand that my health care and payment for my health care will not be affected if I do not sign this form.
I understand that I may revoke this authorization in writing at any time, except to the extent action has already been taken in reliance on it. I understand that this authorization will expire on: _____ (specify date or event) or, if no date or event is specified, 12 months from the date of signing.
A photocopy or fax of this authorization will be treated in the same manner as the original.

_____ _____
Signature of Patient/Guardian/Representative Date

_____
(If not patient, state authority/relationship)