Authorization to Communicate Protected Health Information

Patient Name: _____

Patient Address: _____

_____

Patient Phone Number: _____

Patient Date of Birth: _____

I Hereby Authorize Bonnie Rubin Audiology of Rye Ridge to disclose my protected health information as indicated below.

This information can be communicated to:

____ Spouse _____ ____ Child _____

____ Friend _____ ____ Other _____

1. I understand that I may revoke this authorization at any time by providing written notice to Bonnie Rubin Audiology of Rye Ridge.

2. I am signing this authorization freely and under no pressure from any individual to do so.

Patient Signature: _____ Date: _____