The Kaplan Hearing Center

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HIPAA

(Required by federal law)

This form is to confirm your authorization to use or disclose your protected health information for a special purpose.

I, _____, hereby give permission to The Kaplan Hearing Center, its employees, and sub-contractors to release current, past and future information concerning_____'s medical condition, diagnoses, treatments and recommendations to:

* His/her present and future health insurers
* His/her referring and/or primary health care provider
* Other health care providers caring for him/her
* Health care providers' laboratories/radiology he/she is referred to
* Health care facilities he/she is admitted to
* Authorized reviewers for regulatory compliance, quality assurance and/or peer review
* His/her spouse or significant other_____
* His/her parents_____
* His/her children_____
* His/her employer (required for compensation cases)
* Others_____

This permission will remain in effect until I revoke all or part of it in writing. I understand that Audiology & Hearing Care, LLC will make reasonable efforts to insure his/her privacy, but cannot guarantee the conduct of others who receive this information as allowed above.

Signature_____**Date**_____