Authorization to Disclose Health Information

Patient Name	Date of Birth
Patient Address	

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form. I understand that:

1. This authorization permits Chinatown Hearing Center to disclose your health information including information about medical treatment, audiogram, and medical reports.
    a. I authorize Chinatown Hearing Center to disclose my health information:

Name	Relationship

    The records to be disclosed are: _______All Records ______Doctors Notes
2. **Re-Disclosure:** Information that Chinatown Hearing Center uses or discloses based on the authorization I am giving may be subject to re-disclosure by the person who receives the information and may no longer be protected by the federal privacy rules.
3. **Right to Revoke:** I also understand that I may revoke this authorization at any time by delivering a written revocation to Chinatown Hearing Center 57B Mott Street New York NY 10013.
4. **Refusal:** I have the right to refuse to give Chinatown Hearing Center this authorization. If I do not give the authorization, it will not affect the treatment I receive or the methods used to obtain reimbursement for my care, except, however, if my treatment at Chinatown Hearing Center is for the sole purpose of creating health information for disclosure to the recipient identified in this Authorization, in which case, Chinatown Hearing Center may refuse to treat me if I do not sign this authorization.
5. **Inspect/Copy:** I may inspect or copy the information that Chinatown Hearing Center may send at any time.
6. **Term:** This notice is in effect until written revoke is initiated.

Authorization to file Medicare and Insurance

I hereby authorize my insurance carrier to release payment directly to Chinatown Hearing Center. I understand that Chinatown Hearing Center is a Medicare and Medicaid Provider and will not balance bill you for the services beyond their maximum allowable amount.

Acknowledgement of Notice of Privacy Practices

By signing below, I acknowledge that I have received a copy of Chinatown Hearing Center Notice of Privacy Practices. I have read about the use and disclosure of my health information, and other concerns regarding my health information.

______________________________ ______________________

Signature of Patient Date

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Signature of Personal Representative (if applicable)