# CENTRAL ILLINOIS HEARING, LTD.

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## AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

I authorize Central Illinois Hearing, Ltd. to release protected health information to the person(s) named below:

| Name | Relationship | Phone Number |
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Rights of Patient:
I understand that I have the right to revoke this authorization at any time and I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending a written notification to Central Illinois Hearing, Ltd. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective immediately upon receipt of notification by this Clinic. I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditional on signing this form. This authorization may be in force and effective until revoked by the patient or representative signing the authorization:

_____ _____
Signature of Patient or Personal Representative Date

_____
Description of Personal Representative's Authority (attach necessary documentation)