Jones Institute
for Rehabilitative Audiology, LLC

300 Vestavia Parkway, Suite 2300
Vestavia Hills, AL 35216

Phone: 205-795-2059
www.jonesinaudiology.com

Authorization for Release of Protected Health Information

This form authorizes Jones Institute for Rehabilitative Audiology, LLC (JIRA) to share personal health/medical information that is protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Information about:

Patient Name: _____

Date of Birth: _____

Address: _____

Phone: _____ E-mail: _____

May be shared between JIRA and the following:

Name: _____

Agency: _____

Address: _____

Phone: _____ Fax: _____

E-mail: _____

Specific description of the heath information to be shared (*include dates of service, appointment dates, type of service, etc.*):

_____

Information may be shared using a variety of methods, including, but not limited to, by phone, in writing, by fax, via computer file, or by email unless otherwise directed or restricted below.

_____ No restrictions

_____ Other directions/restrictions: _____

The purpose of this release is: _____ Coordination of care for the named patient.

_____ Other (specify): _____

My signature below indicates I understand and agree that:

- Only information that is specified above and needed to fulfill the purpose(s) listed above will be released.
- This authorization is voluntary. I may refuse to sign this authorization and the patient's treatment and/or payment obligations will not be affected unless either of the following applies: (a) treatment is related to research and the sharing of information is related to such research; or (b) treatment is solely for the purpose of creating protected health information for disclosure to a third-party.
- JIRA will not receive financial or in-kind compensation or remuneration in exchange for sharing protected health information unless an applicable legal exception applies.
- Health information shared may be subject to redisclosure by the recipient of the health information and may no longer be protected by federal or state law.
- Unless otherwise revoked, this authorization will expire on _____ (date, event, or condition). If I fail to specify a date, event, or condition, this authorization will expire in one (1) year.
- I may revoke this authorization at any time by notifying JIRA in writing, but, if I do, it will not have any effect on uses or disclosure prior to the receipt of the revocation.
- I can ask for a copy of this signed form, as well as a copy of any records shared.
- A photocopy or facsimile of this authorization will be valid and effective, just as the original.

I have the authority to give the permission described above and am doing so voluntarily.

_____ _____ _____

Patient Signature if 14 or older | Printed Name | Date

_____ _____ _____

Parent/Guardian/Personal Representative (if applicable) | Printed Name | Date

_____

Relationship of Representative to Patient (if applicable)

Rev. 11-28-2012