Hearing Healthcare Professional Authorization

Nardelli Audiology

By signing this form, I understand that I am giving Nardelli audiology authorization to use or disclose the following information:

Specify information to be disclosed: Hearing Information / Audio

Recipient My health information described above may be disclosed by Nardelli Audiology to the following person (s) or class of persons: X.

Right to Revoke I understand that I may restrict the individuals or organizations to which my healthcare information is released. Further, I understand that I may revoke my authorization at any time; however, my revocation must be in writing, mailed to Nardelli Audiology at the address listed below, and Nardelli Audiology must only comply with such revocation to the extent it is consistent with its Notice of Privacy Practices.

Re-disclosure Information that Nardelli Audiology 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.

Refusal I have the right to refuse to give Nardelli Audiology 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 Nardelli Audiology is for sole purpose of creating health information for disclosure to the recipient identified in this Authorization in which case Nardelli audiology by refuse to treat me if I do not sign this Authorization.

Inspect/Copy I may insect or copy the information that Nardelli Audiology may send at any time.

Term This notice is effective as of the date set forth below and will remain in effect until: Check one of the following):

- ○ The following date or event:
- ○ Nardelli Audiology fulfills the request
- ✓ I provide written notice of revocation to Nardelli Audiology. The revocation will be effective immediately upon Nardelli Audiology receipt of my written notice, except that the revocation will not have any effect on any action taken by Nardelli Audiology in reliance on this Authorization before it received my written notice of revocation

Purpose I authorize Nardelli Audiology to use or disclose my health information in the manner described above to the receipt for the term for the following specific purpose ("At the request of the Patient" is sufficient if the patient is initiating the Authorization) X

Contact I may contact Nardelli Audiology by mail at 620 Rose Bud Plaza, Clarksburg, WV 26301 or by telephone at : 304-622-9428.

I hereby acknowledge that I have received a copy of this Authorization. I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. By my signature below, I hereby knowingly and voluntarily authorize Nardelli Audiology to use of disclose my health information in the manner described above.

X _____ _____

Signature of Patient (or Personal Representative) Date

X _____ _____

Printed Name of Patient Date