INDIVIDUAL PATIENT AUTHORIZATION
SAHAC LLC dba Sound Advice Hearing Aid Centers
Main Office: 1118 East Main St, Salisbury, MD 21804
800-432-7012

Individual Patient's Name: ____

Address: ____

Phone Number: ____

E-mail address: ____

I authorize __________________________ (Provider) to use and/or to disclose my protected health information for the purpose of diagnosing or providing hearing care and treatment to me. Name the people and/or organizations (or the kinds of people and/or organizations) that you are authorizing to receive and use your protected health information:

____

I understand that I may revoke this authorization at any time by giving written notice to the Contact Office listed above. However, I understand that I may not revoke this authorization for any actions taken before receipt of my written notice to revoke this authorization.

Also, I may be required to sign an authorization if my treatment is provided solely for the purpose of creating protected health information for disclosure to a third party.

Signature ____ Date _____/_____/_________

If this authorization form is signed by a personal representative for the individual patient, complete the following:

Personal Representative (Print Name): ______________________________________

Relationship to Individual: ____

YOU HAVE A RIGHT TO A COPY OF THIS FORM AFTER YOU SIGN IT