NewGen
Hearing Centers
Dr. Joseph K. Durán

AUTHORIZATION

Patient's Full Name: ______________________________________ Date of Birth: ___/___/___

Address: _______________________ Apt: _____ City: __________ State: _____ Zip: _____

1. Check one:

☐ I hereby authorize New Generation Hearing Centers to use protected health information concerning the above-named person.

☐ I hereby authorize New Generation Hearing Centers to disclose protected health information concerning the above-named person to:

____

Name(s) of person(s)/organization(s) or class(es) of persons/organizations to which disclosure is to be made.

☐ I hereby authorize ____ to disclose protected health information concerning the above-named person to new generation hearing centers.

For treatment date(s): ____

For the following purpose(s):____

If the request is initiated by the individual (or his/her representative), insert "at the request of individual;" otherwise, describe purpose of the use or disclosure. If the purpose relates to marketing, indicate whether New Generation Hearing Centers will receive remuneration.

2. Check type of information authorized to be used and/or disclosed: *Unless the appropriate box is checked, New Generation Hearing Centers will not disclose records contained in its medical records prepared by healthcare providers not affiliated with New Generation Hearing Centers unless the records were prepared on behalf.*

☐ Physician orders
☐ Payment Records
☐ Test Results
☐ Consultation Notes
☐ Billing Records
☐ Other: __________________________
☐ Records not prepared by or on behalf of New Generation Hearing Centers. New Generation cannot be responsible for the completeness or accuracy of such records.
☐ Entire Record (will not include Billing Records or Physician Orders records not prepared by or on behalf of New Generation Hearing Centers) unless those items also are selected.

This authorization shall remain in effect until ___/___/___ (date) or ___________________________ (occurrence of specified event) at which time this authorization to disclose the identified health information expires, but no later than one year from the date listed below. If this item is left blank, the authorization shall remain effective for 60 days after the date listed below.

I understand that the records to be used or disclosed pursuant to this authorization may contain ________ records relating to participation in any federally assisted drug and alcohol abuse program; ________ information relating to diagnosis and treatment of mental, alcoholic, drug dependency, or emotional condition, other than notes recorded by a mental health professional documenting or analyzing conversation during a counseling session provided such notes are maintained separately (unless this authorization pertains specifically to psychotherapy notes); ________ information relating to HIV testing, HIV status, or AIDS. I understand that such information is subject to special protections pursuant to state and federal laws and regulations. **By my initials, I authorize the use or disclosure of records containing such information if they are otherwise included within the scope of this authorization.**

I, the undersigned, have read the above and authorize the disclosure of such health information as described herein. I understand that treatment is not conditioned upon the execution of this authorization. I understand that if the person or entity that receives the information is not a healthcare provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations. I understand that fees may be charged for preparing and sending copies of records, Per the State of Florida Rule 64B8-10.003, Costs of Reproducing Medical Records, the cost for the reproduction of medical records is $1.00 per page. I understand that I may revoke this authorization at any time by providing a written notice to the person identified below except to the extent that action has been taken in reliance upon it or except as otherwise stated in New Generation Hearing Centers' Notice of Privacy Practices by mailing or hand-delivering written notification to the following person**:** Privacy Officer, Yvette Duran Someillan, New Generation Hearing Centers, 3431 SW 107 Ave, Miami, FL 33165.

____________________________________	____
Date	*Signature of Individual/Individual Representative*
____________________________________	____
Printed Name of Representative and Relationship	*Representative address and telephone number*
____________________________________	____
Date	*Signature of Witness*

ORIGINAL – New Generation Hearing Centers | Records COPY – Individual