

**AUTHORIZATION FOR DISCLOSURE
OF CONFIDENTIAL INFORMATION**

I, _____, DOB _____ authorize Premium Hearing Solutions to disclose the information specified below to the following locations(s):

- | | |
|--------------------------------------------------|--------------------------------------------|
| <input type="checkbox"/> Medical Records | <input type="checkbox"/> Medical Reports |
| <input type="checkbox"/> Audiological Records | <input type="checkbox"/> Real Ear Measures |
| <input type="checkbox"/> Extended Warranties | <input type="checkbox"/> Chart Notes |
| <input type="checkbox"/> Hearing Aid Specs/Eval. | <input type="checkbox"/> Bill of Sale |
| <input type="checkbox"/> Repair form/work orders | <input type="checkbox"/> Other: _____ |

I am aware of the confidential and/or privileged nature of the information being disclosed, and understand the benefits and/or disadvantages of disclosing such information. I hereby release Premium Hearing Solutions from all legal liabilities that may result from the release of this information.

I realize I have the right to revoke this authorization at any time, by sending written notification to Premium Hearing Solutions.

I understand that the information disclosed may be subject to redisclosure by recipient, and may no longer be protected by federal and state privacy laws and regulations.

I understand the above, and request that my records be provided to the above as promptly as possible.

Date: _____ Signature: _____

Notice to recipient: This authorization provides for a release of information about an individual whose confidentiality is protected by federal and state laws and regulations, including the Health Insurance Portability and Accountability Act of 1996 and state confidentiality laws. No information disclosed from this authorization may be re-disclosed without the specific written consent of the individual about whom such information pertains.