AHAS
DOCTORS OF AUDIOLOGY

# HIPAA

As a result of the Health Insurance Portability and Accountability Act (HIPAA), enforced by the US Department of Health and Human Services office of Civil Rights, we are not permitted to release patient information except as stated in the Notice of Privacy Practices, or in accordance with your wishes as stated below.

This waiver authorizes AHAS to send/give information as noted:

| | | |
|---|---|---|
| Leave a voicemail recording including my Personal Health Information on my home/cell phone. | Yes | No |
| Use of electronic communication (I.e., email, fax, electronic messaging) to transmit Personal Health Information. | Yes | No |
| Permit the individual stated below (Personal Representative) to receive my Personal Health Information. | Yes | No |
| Speak to my Personal Representative about my Personal Health Information. | Yes | No |

Name of Personal Representative: _____

The authorizations made above will remain effective until such time as I notify AHAS in writing of requested changes.

Patient Printed Name: _____

Patient Signed Name: _____ Date: _____