Authorization and Release for the Use and/or Disclosure of Protected Health Information for Marketing

Patient Name: **Date of Birth:**

____By initialing this section and signing below, I authorize Audiology Experts to send me educational and/or marketing information on the products and services offered by Audiology Experts. No remuneration is involved in this communication. I understand that I may revoke this authorization, in writing, at any time.

Printed name of patient or personal representative	**Date**
Signature of patient or personal representative	**Date**

If you need assistance in completing the authorization form, please contact our office at hearing@audiologyexperts.com.

I understand that I have the right to request restrictions as to how my protected health information may be used or disclosed by Audiology Experts.

I authorize Audiology Experts' use and disclosure of my protected health information as set forth above. I understand that this authorization is voluntary and that Audiology Experts cannot condition my treatment, services, etc on the signing of this authorization. I understand that if I am signing on behalf of a minor child, this authorization will expire upon the child reaching the age of 18, unless there is proof of legal guardianship.

REVOCATION SECTION

Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice to the address listed at the bottom of this form. I understand that revocation of this authorization will not affect any action the above named entity took in reliance on this authorization before the above named entity received my written notice of revocation.

I hereby revoke this authorization.

_____	_____
Printed name of patient or personal representative	Date
_____	_____
Signature of patient or personal representative	Date