Acct # _____

AUTHORIZATION FOR RELEASE OF INFORMATION

MUST FILL OUT COMPLETELY

I hereby authorize Lyuba Nemanov, Au.D. to use or disclose my Personal Health Information (PHI) as described below. I understand that, if the organization authorized to receive my PHI is not a health plan or health care provider, the released PHI may no longer be protected by federal privacy regulation. Our Notice of Privacy Practices provides detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practice. It is available upon request.

Patient authorizes communication with family/friends regarding your **care and test results.**

Name _____ Phone # _____ Relation_____

Name _____ Phone # _____ Relation_____

Patient authorizes communication with family/friends regarding your **account and billing. Next of kin.**

Name _____ Phone # _____ Relation_____
Address:_____City_____State____ Zip_____

Patient authorizes communication with a primary care physician or other physician (first and last name):
1. _____ M.D.
2. _____ M.D.

Best way to contact you regarding messages, responses, appointment reminders etc. (number 1· 5, 1 being the best)
Home phone__ Work phone__ Cell phone__ E-mail Text

May we leave a message on home voicemail?	Yes	No	N/A
May we leave a message with whomever answers the home phone?	Yes	No	N/A
May we call your work and leave a message with the person who answers the phone?	Yes	No	N/A
May we leave a message on work voicemail?	Yes	No	N/A

May we contact you via Email? Email Address:_____

May we contact you via text message? _____	Yes	No	N/A
May we send out your Private Heath Information to an electronic medical record system?	Yes	No	N/A

You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your PHI in reliance on your consent.

May we fax and/or email to other providers if necessary to medical care	Yes	No	N/A

Signature of patient (or patient's representative)_____ Date _____

Printed legal name of patient (or patient's representative) _____