CLEVELAND Hearing & Speech CENTER℠

11635 Euclid Avenue · Cleveland, OH 44106 · 216-231-8787 · 216-231-7141 Fax
4257 Mayfield Road · South Euclid, OH 44121 · 216-382-4520 · 216-325-7609 Fax
7000 Town Centre Drive #200 · Broadview Heights, OH 44147 · 440-838-1477 · 216-325-7620 Fax

AUTHORIZATION FOR RELEASE OR USE OF PROTECTED HEALTH INFORMATION

Client Name:	Date of Birth:
Client Address:	

I, _____, authorize The Cleveland Hearing & Speech Center to obtain, use, disclose, and exchange protected health information regarding above named client with the individuals or entities listed below for the purposes of providing, coordinating, and managing treatment, payment, and healthcare operations. This authorization includes written, verbal, and email communications.

The protected health information and education information can be obtained from, disclosed to, or shared with:

Parent/Client Name:	
Address:	Phone #:
	Fax #:
Name:	
Address:	Phone #:
	Fax #:
Name:	
Address:	Phone #:
	Fax #:
Name:	
Address:	Phone #:
	Fax #:

The specific protected health information to be disclosed: (check all categories that apply)

❑ Speech-language evaluations, progress reports, and daily notes
❑ Audiologic records including evaluation, treatment records, and observations
❑ Neuropsychological reports
❑ School records including special education information (including evaluations and plans such as IEP/MFE/CSP/IFSP)
❑ Entire medical records, including patient histories, office notes, test results, operative reports, radiologic studies, referrals, consults, billing records, insurance records, and records sent by other health care providers
❑ Other (specify) _____
❑ Include (indicate by initialing): ____ Alcohol/Drug Treatment ____Employment Records
____ Mental Health Information ____Other: _____
____ HIV Related Information

By signing below, I understand that:

- This authorization shall expire one year from the date I sign this authorization.
- I have the right to revoke or cancel this authorization at any time by providing notice in writing to: HIPAA Compliance Officer, CHSC, 11635 Euclid Avenue, Cleveland, Ohio, 44106. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization. Additional information is available in the Notice of Privacy Practices.
- Any information used or disclosed as per this specific authorization may be re-disclosed by the person or entity receiving the information. In such a situation, the information may no longer be protected by federal or state law.
- I am not required to sign this authorization. If I refuse to sign this form, it will not affect my ability to receive treatment, payment for care, or eligibility for benefits from The Cleveland Hearing & Speech Center.
- I understand that this information may include disclosure of information related to alcohol and drug abuse, mental health treatment, and confidential HIV related information if indicated above.
- I have the right to receive a copy of this signed authorization.
- I have a right to inspect or copy the protected health information that will be used or disclosed per this authorization.

Client (or Personal Representative of Client) Signature:	
Relationship to Client (parent, guardian, power of attorney, etc.)	Date Signed: