

Medical Record Disclosure

Authorization for Use or Disclosure of Protected Health Information (Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

The following authorization form must be completed if requesting medical records be sent to *anyone* other than the referring physician. Patient Name: ______ DOB: _____ I authorize Garden State Hearing & Balance Center, Inc. to disclose the protected health information of the above named patient to the following individual/entity: Phone ☐ All testing results ☐ Results from visit dated ______ Patient/Guardian Signature GSHB Staff Date Date **Patient/Provider Electronic Communication Agreement** While electronic communication (Email) is a convenient way to improve communications between patients and healthcare providers, there are risks associated with using Email that you need to consider. By agreeing to Email communications you will not hold Garden State Hearing & Balance Center, Inc. responsible for accidental or inadvertent transfer of personal medical correspondence to unintended individuals or institutions. We will remain responsible for any malicious or deliberate inappropriate transfer of information by us and will follow legal requirements protecting your medical information. Either of us may revoke this arrangement at any time by written notice. If you understand these risks and agree to these conditions, please sign and return this form. ☐ I am requesting the use of electronic communications (Email) between myself/or my child (the patient) and Garden State Hearing & Balance Center, Inc. Email address:

Date

GSHB Staff

Date

Patient/Guardian Signature