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

I authorize Central Florida Speech & Hearing Center to use/disclose my protected health information for marketing related to audiological/health-related products or services. I understand that Central Florida Speech & Hearing Center or its business associates may receive financial remuneration in exchange for making the marketing communication from or on behalf of the third party whose product or service is being described. I understand that if the person/organization authorized to receive and use the information is not a health plan or care provider; the disclosed information may no longer be protected by federal privacy regulations. *(Please select only one box below)*

* **I authorize** Central Florida Speech & Hearing Center to use and disclose medical information for any and all marketing purposes and understand that Central Florida Speech & Hearing Center or its business associate may receive financial remuneration in exchange for making the marketing communication for on behalf of the third party whose product or service is being described. A list of anticipated and potential persons/class of or persons/organizations to whom information may be disclosed is included below.
* **I request an authorization form for each instance** Central Florida Speech & Hearing Center intends to use and disclose medical information for any marketing purposes and understand that Central Florida Speech & Hearing Center or its business associate may receive financial remuneration in exchange for making the marketing communication for on behalf of the third party whose product or service is being described.
* **I prohibit** Central Florida Speech & Hearing Center from using and disclosing medical information for any marketing purposes.

A list of anticipated and/or potential persons/class of persons/organizations to whom information may be disclosed:

If you need assistance in completing the authorization form, please contact Sue Poulsen, at spoulsen@cfshc.org.

I understand that I have the right to request restrictions as to how my protected health information may be used or disclosed by Central Florida Speech & Hearing Center. I understand that this authorization is in effect for the term set forth below or until the revocation section of this form is signed and received. I may revoke this authorization at any time by signing the revocation section of my copy and returning it to **Central Florida Speech & Hearing Center**. I authorize Central Florida Speech & Hearing Center’s use and disclosure of my protected health information as set forth above. I understand that this authorization is voluntary and that Central Florida Speech & Hearing Center cannot condition my treatment, services, etc., on the signing of this authorization. I understand that if I am signing on the behalf of a minor child, this authorization will expire upon the child reaching the age of 18, unless there is proof of legal guardianship.

By signing below I agree that I have been advised of Central Florida Speech & Hearing Center’s authorization and release for the use and/or disclosure of protected health information for marketing practices and procedures.

**Authorization to Observe**

Central Florida Speech and Hearing Center is partnered with the University of South Florida (USF) and other educational facilities/programs, to educate graduate clinicians and students.  As a result, graduate clinicians from USF and other educational programs may observe clinical services provided at the Central Florida Speech and Hearing Center.  By signing below, you provide consent for student observation.

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

I acknowledge that I received a copy of Central Florida Speech & Hearing Center’s Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, the website (if applicable) and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

* This Notice informs me of how Central Florida Speech & Hearing Center will use my health information for the purposes of my treatment and/or payment for my treatment.
* This Notice explains in more detail how Central Florida Speech & Hearing Center may use and share my health information for other than treatment, payment and health care operations.
* Central Florida Speech & Hearing Center will also use and share my health information as required/permitted by law.
* By signing below I agree that I have been advised of Central Florida Speech & Hearing Center’s Notice of Privacy Practices.

**Signature section for:**

* Authorization & Release for the Use and/or Disclosure of Protected Health Information for Marketing
* Authorization to observe
* Privacy practices

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**Printed Name** of patient Date of Birth

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**Signature** of patient or personal representative Date

**Below this line is for future use or STAFF USE ONLY**

***\*\*\*\*\*Expiration / Revocation Section\*\*\*\*\****

***Expiration:*** *This authorization will expire on* ***(must choose ONLY one)****:*

* ***1 year from the date it is signed***
* ***Other*** *(insert date or event): \_\_\_\_\_\_\_\_\_\_\_\_\_\_*

***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.*

*By signing below I hereby revoke this authorization.*

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

***Printed Name*** *of patient or personal representative Date*

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

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