Everclear Hearing Products, LLC

AUTHORIZED REPRESENTATIVE FORM
(SHARED MEDICAL INFORMATION)

Note: This form is used to confirm a Patient's permission that the health plan/provider may discuss or disclose their Protected Health Information to a particular person who acts as their Authorized Representative. Use of the Protected Health Information is strictly limited to that purpose.

Section A: Patient Information

By signing this form in Section E below, I understand and agree that **Everclear Hearing Products, LLC** may release my personal health information (PHI) as defined in Section B below to my Authorized Representative(s) named in Section C below.

Patient Name: _____

Address: _____

Telephone Number: _____ Patient ID Number: _____

E-mail Address: _____

Please Note: This authorization does not provide your "Authorized Representative" with any authority, either implied or direct, over any treatment or direct care decisions. If you wish to designate a health care partner/proxy or a clinical personal health care representative or if you want to set up a living will or power of attorney, please discuss this with your attorney or health care provider. Also, the provider/plan will not condition treatment, benefits payments, enrollment, or eligibility for benefits on the execution of this form.

Section B: Type of Information

- Personal Health Information (PHI), including, but not limited to, identification of treating providers of care, diagnoses, procedures, demographic information.
- This information may include diagnoses and/or treatment for alcohol and/or drug abuse; AIDS/AIDS Related Complex (ARC) and HIV diagnoses and/or treatment; and diagnoses and/or treatment relating to other communicable diseases
- This authorization does not cover disclosure of psychotherapy notes.

Section C: Authorized Use and / or Disclosure

Intended Use or Disclosure:

I understand that the provider/plan's general policy is not to disclose my personal health information to other parties, except those directly involved in my care, without my written authorization or as permitted or required by law. For this reason, I authorize you to discuss and disclose my personal health information to the person(s) named below for the purpose of assisting with, or facilitating, the coordination or payment of my health plan benefits. I also understand that if my Authorized Representative is not a health care provider or another entity subject to federal or applicable state privacy laws, my personal health information may no longer be protected by those privacy laws and my personal health representative may further disclose my personal health information without my authorization. I acknowledge that my authorization is voluntary.

Authorized Representative #1:

Name: _____ **D.O.B** _____ **Phone Number**: _____

Address: _____

Relationship to You _____

Authorized Representative #2:

Name: **D.O.B.** **Phone Number**:

Address:

Relationship to You: _____

Authorized Representative #3:

Name: **D.O.B.** **Phone Number**:

Address:

Relationship to You: _____

I understand that I have the right to limit the information that you release under this authorization. For example, I may limit my Authorized Representative's access to information about a particular health care provider or a particular diagnosis/disease. Any such limitations must be described below in writing. I understand that by leaving this section blank, I am creating no limitations on disclosure.

Limitations on Disclosure:

_____
_____
_____

Section D: Expiration and Revocation

This authorization to release information to my Authorized Representative will automatically expire two years following the termination of my health plan enrollment.

I understand that I have the right to revoke or end this authorization at any time. I understand that, if I do not wish the person(s) named in Section C to remain my Authorized Representative, I must revoke this authorization **in writing** by giving written notice of my decision to the health plan contact listed below. I understand that my revocation of this authorization will not affect any action that you have taken, or any information that you have already released, based upon this authorization before you actually receive my request to revoke it.

Contact Person: Patrice Rogstad **Telephone: 715-831-0289**
Address: 2215 E Clairemont Ave, Ste 5, Eau Claire, Wi 54701 Fax: 715-831-4722

Section E: Signature / Authorization

I have had full opportunity to read and consider the content of this Authorized Representative Form. I confirm that this authorization is consistent with my request of the health plan and its administrator. I understand that, by signing this form, I am confirming my authorization that the health plan may use and/or disclose my personal health information to the person(s) named in Section C for the purpose described above. I also confirm that a facsimile copy of this form is acceptable.

Signature: **Date**

Please Return the signed Authorization Form to the Contact Person listed in Section D. You are entitled to a copy of this Authorization Form after you sign it.