WRSD Audiology | Release of Information Form

Willie Ross School for the Deaf
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AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize the use or disclosure of my individually identifiable health information including all of the information that the provider has in his/her possession (e.g., information related to any medical history, mental or physical condition, and any treatment I receive). I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

_____ _____
Patient Name Date of Birth

I hereby authorize Willie Ross School for the Deaf, Inc. (WRSD) to ***release*** information contained in my records ***to*** the following individuals (doctors/family members) or organizations (schools), i.e., who should we send the audiological records to:

1. _____
   _____/_____/_____/_____/_____
   Address City State Zip Code Phone Number
2. _____
   _____/_____/_____/_____/_____
   Address City State Zip Code Phone Number
3. _____
   _____/_____/_____/_____/_____
   Address City State Zip Code Phone Number

I hereby authorize WRSD to ***obtain*** information contained in my records ***from*** the following individual (doctors) or organizations (schools), i.e., who should we request audiological records from:

1. _____
   _____/_____/_____/_____/_____
   Address City State Zip Code Phone Number
2. _____
   _____/_____/_____/_____/_____
   Address City State Zip Code Phone Number
3. _____
   _____/_____/_____/_____/_____
   Address City State Zip Code Phone Number

I understand that I have the right to revoke this authorization at any time by providing a written notice of revocation to WRSD. This does not apply to information that has already been released prior to receiving the revocation. If not previously revoked in writing, this authorization will last for **one year from the date that this document is signed.**

WRSD and its employees are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

I understand that this authorization is voluntary and will not affect the commencement, continuation, or quality of my treatment. I may refuse to sign this authorization but records cannot be released without my signature.

_____ _____
Patient Signature Date

_____ _____
Parent/Guardian Signature Date

_____ _____
Witness Date

Revised: 9/2023