CODY AUDIOLOGY CLINIC
Dr. Brandi R. Shepard

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Preferred Form of Communication: ____HOME ____CELL ____ WORK

____ Home Phone-ok to leave messages regarding appointments or request call to our office Cell Phone

____ To leave message with detailed information

____ Work Phone-ok to leave message with call back number

I HEREBY GIVE MY AUTHORIZATION TO DISCLOSE MY PROTECTED HEALTH INFORMATION TO THE SPECIFIC INDIVIDUAL(S) LISTED BELOW. PLEASE CHECK ALL THAT APPLY

____ I do not want Cody Audiology Clinic to speak to anyone (other than my primary care physician, or physician being referred to by this office, if applicable)

____ It is acceptable for Cody Audiology Clinic to speak with only the following individual(s) regarding my condition (**please check all that apply and provide their name(s):**

Spouse/Partner: _____

Parents/Guardians: _____

Siblings/Children: _____

School: _____

Medical Providers: _____

Other: _____

This authorization will expire on _____ (expiration date or defined event)
If no date/defined event indicated, authorization will remain in place until further notice.

It is the patient's responsibility to notify office staff of any changes to this authorization. A copy of this authorization is considered valid. I, _____ agree and understand that my electronic signature is the legal equivalent of my handwritten signature.

Patient Name _____ _____
DOB

_____ _____
Patient/Responsible Party Signature Date