HORAN & FEVOLD
Hearing Clinic, PLLC

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Doctors of Audiology

Authorization for Communication of Protected Health Information to Family Members and Friends

PATIENT	DOB [MO/DY/YEAR)
ADDRESS	PHONE ( )
CITY	STATE/ZIP

1. I authorize Horan & Fevold Hearing Clinic, PLLC to discuss/share protected health information about me with the following individual(s) who are involved in my care:

____
Printed Name   Relationship   Phone Number

____
Printed Name   Relationship   Phone Number

2. Type of information to be shared or disclosed:

- □ Appointment information
- □ Billing information
- □ Treatment information
- □ ALL information

3. I authorize Horan & Fevold Hearing Clinic, PLLC to leave detailed phone messages about my medical and health plan information with the following:

- □ Voicemail/Answering Machine
- □ Person answering home or cell phone
- □ Text Message (Cell)

- □ Email Address:_________________________________@____________________

This authorization shall remain in effect until revoked in writing by the patient. Submitting a new form will revoke existing form.

____   _______________
Signature of Patient/Authorized Individual   Date

MAIL TO:
Horan & Fevold Hearing Clinic, PLLC

610 N Mission St, Suite 120
Wenatchee, WA 98801

423 W Third Ave, Suite A
Moses Lake, WA 98837

FAX TO:
(509) 665-9980 – Wenatchee
(509) 764-8644 – Moses Lake