HORAN & FEVOLD HEARING CLINIC, PLLC
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
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
Attn: Privacy Officer
1556 N Wenatchee Ave, Suite D
Wenatchee, WA 98801

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

FAX TO:

HORAN & FEVOLD HEARING CLINIC, PLLC

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

(509) 665-9980 – Wenatchee
(509) 764-8644 – Moses Lake
Attn: Privacy Officer